

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01903 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST George V. Adam		2a. DATE OF DEATH		MONTH DAY YEAR 1-24-Jan. 24 1979		2b. HOUR 12 ¹⁰ A M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 15 1894		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Yugoslavia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waiter (Retired)		12b. KIND OF BUSINESS OR INDUSTRY Food			
13a. STATE Maryland						13b. COUNTY Prin. Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Vasilios Adam						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Unobtainable					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 166-01-7384		17 INFORMANT Mrs. Mary Adam		ADDRESS 6620 23rd Ave., Hyattsville, Md. 20782					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Resp. -> Card arrest probably 2° to MI</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>C.H.F.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ILASID C LVN and A-fib C</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>rapid vent. response</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Transient Symptomatic arrhythmias possibly 2° to Dig Sensitivity</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 23</u> , 19 <u>78</u> , to <u>Jan 28</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Jan 23</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (I) did not view the body after death.											
22b. SIGNATURE <u>Mark Andrews</u>		DEGREE MD		22c. DATE SIGNED 1/24/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark Andrews		22e. ADDRESS W A H. FHC Takoma Park md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/26/79		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prin. Geo. Md.					
24 FUNERAL DIRECTOR NAME Hines/Rinaldi		11800 New Hampshire Ave., Silver Spring, Maryland 20904				25a. DATE REC'D. BY REGISTRAR JAN 29 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

5116

.A.3.U

John. Advanced Hosp.

Print. Geo. W. W. W. W.

Helen

100-01-7384 Rev. 10-80

25/02/11

11800 New Hampshire Ave.

Per. Montgomery County Police

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01904 REG. NO.							
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jack NMN Alter				2a. DATE OF DEATH MONTH DAY YEAR January 16, 1979				2b. HOUR 1:05P M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12/12/1895		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14010 Cove Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Food Merchant			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST David Alter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Bernstein							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 082 03 6192A		17 INFORMANT ADDRESS Norman Alter 168 Baraud Rd. Scarsdale, New York 10583					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cerebrovascular Disease</u> 4370 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Carcinoma of prostate</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (i) (this hospital) attended the deceased from <u>2-15</u> , 19 <u>78</u> , to <u>1-16</u> , 19 <u>79</u> , that (i) (we) lost saw the deceased alive <u>1/1</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Bernard A. Heckman, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/16/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. HECKMAN, M.D.				22e. ADDRESS 8830 Cameron ST. Silver Spring, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/17/79		23c. NAME OF CEMETERY OR CREMATORY Westchester Hills Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Hastings on the Hudson, N. Y.			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. Rockville, Md.						25a. DATE REC'D. BY REGISTRAR JAN 19 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

5993 BP

DHMH-16 50M 7/77
(VRA 15 (4))

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-01905 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BARBARA L ANDERSON			2a. DATE OF DEATH MONTH DAY YEAR 1-31-79		2b. HOUR 7:15 AM
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 12-19-39		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVERSPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrative Clerk		12b. KIND OF BUSINESS OR INDUSTRY Telephone co
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md		13c. COUNTY Pro Georges	13d. CITY OR TOWN Adelphi	13e. STREET ADDRESS 9301 19th ave	
14. FATHER'S NAME FIRST MIDDLE LAST James G Gabbard			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vennie Newton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 232 58 2650		17. INFORMANT ADDRESS Gary Anderson Adelphi, Md.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coma</u> <u>1749</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Breast Cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 HR.</u> <u>3 1/2</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1128</u> , 19 <u>79</u> , to <u>1131</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1130</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED 11/31/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDGAR H. LEVIN		22e. ADDRESS 8630 FENTON Silver Spring Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb 3, 1979	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pro Georges Md.	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons P A		ADDRESS Hyattsville, Md.		25a. DATE REC'D. BY REGISTRAR FEB 6 1979	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

20210-05

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										79-01906	
1- FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Neva A ATKINS					2a. DATE OF DEATH MONTH DAY YEAR 1 7 79			2b. HOUR 4 25 PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 2-12-82		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wildwood Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6208 Leekeforest Court			
14. FATHER'S NAME FIRST MIDDLE LAST Ogden A. Starbuck					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Nelson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217 52 7270		17. INFORMANT ADDRESS Craig S. Atkins same as item 13						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory collapse DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia - mixed flora DUE TO, OR AS A CONSEQUENCE OF (c) Chronic brain syndrome assoc. with cerebral arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) cerebral arteriosclerosis											
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —			21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — —					
22a. I certify that (I, the funeral director) attended the deceased from 3/25/79 to 1/7/79, that (I, we) lost saw the deceased alive on 1/7/79, 1979, and that in (my, our) opinion death occurred on the date and hour and from the causes stated above. (we) (I, we) did not view the body after death.											
22b. SIGNATURE John O. Allin M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/7/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John O. Allin M.D.					22e. ADDRESS 8218 Wisc. Ave Bethesda, Md 20014						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/11/79		23c. NAME OF CEMETERY OR CREMATORY Shady Grove Wesleyan Church Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Colfax, North Carolina				
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND					25a. DATE REC'D. BY REGISTRAR JAN 16 1979		25b. REGISTRAR'S SIGNATURE [Signature]				

78-01906



DATE



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01907 REG. NO.	
1. FOR STATE REGISTRAR MAY 1979					
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE A. LAST Ayers			2a. DATE OF DEATH MONTH DAY YEAR 1-25-79		2b. HOUR 1:55 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 16, 1898	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Kensington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Circle Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Vet. Adm.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Kensington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 10416 Fawcett St. Apt. # 4	
14. FATHER'S NAME FIRST MIDDLE LAST Walter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Carpenter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI 577-03-2976	17. INFORMANT ADDRESS Mrs. Jean Markward Kensington, Md. 10416 Fawcett St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Organic brain syndrome 4409 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs cpx					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Dehydrated malleles					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/14, 1976, to 1/25, 1979, that (I) (we) lost saw the deceased alive on 1/25, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Barry Rosenbaum, M.D.		DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry Rosenbaum, M.D.		22e. ADDRESS 3720 Farragut Ave. Kensington, M.D.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/27/79		23c. NAME OF CEMETERY OR CREMATOR Ft. Lincoln Cem.	
23d. LOCATION CITY OR TOWN Brentwood, Md.		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C.		25a. DATE REC'D. BY REGISTRAR JAN 31 1979		25b. REGISTRAR'S SIGNATURE Pottery McCready	

BP

70010-02

VOIDED #01908 FEBRUARY, 1979 DEATH

SEE BERNARD BAILES, MONT. 2/1/79



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01909

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Irene Frances Barnes			2a. DATE OF DEATH MONTH DAY YEAR 1-11-79			2b. HOUR 11:50 A.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 26 1896		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH T.P.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Adv. Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William H. Finn				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Mumford				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 011 22 5310		17. INFORMANT ADDRESS Edward Barnes (Son) Same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) 486- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) 8 days DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Pneumonia, Spontaneous pneumothorax								
19a. DATE OF OPERATION 1-4-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pneumothorax			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1-1-79 , to 1-11-79 , that (I) (we) last saw the deceased alive on 1-10-79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Seruch T. Kimble M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-12-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Seruch Kimble				22e. ADDRESS 9801 Marina Ave, Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/13, 1979		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Wash. D.C.		
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.				ADDRESS 11800 N.H. Ave. Silver Spring, Md.		25a. DATE OF DEATH JAN 16 1979		
				25b. REGISTRAR'S SIGNATURE [Signature]				

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this form should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



79-01909

Female	White	Feb. 28 1898	22
Vermont	USA	X	Manager
T.P.	Wash. Adv. Hospital		Honolulu
Ms.	Mont.	Richards	9801 Webster Dr.
William H. Finn	Annie Munford		
No	011 22 2310	Edward Barnes (son)	Same as above

Boxing 1/14, 1970 M. Oliver Cemetery Wash. D.C.
Ringside 7. H. 11800 N. H. Ave. Silver Spring, Md.

Search Results

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		79-01910 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST Joseph		MIDDLE T.		LAST Barone		2a. DATE OF DEATH MONTH DAY YEAR	
Joseph		T		Barone		11/18/79		2b. HOUR 1238 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR IF UNDER 24 HRS	
Male		White		March 25, 1919		59 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New Jersey		U.S.A.				Mont.		MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross		Real estate consultant					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Montgomery		Silver Spring				11235-Oakleaf Drive	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Anthony - Barone		Carmella - Augenti		No None		156-08-1844		Silver Spring, Md.	
								H. Manny Holtz-executor 2311-University Blvd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> 1889 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Septic massive hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Concomitant of wound</u> 6 months								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Nov. 29, 1978		Concomitant of wound							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Nov. 24, 1978, to 1/18, 1978, that (I) (we) last saw the deceased alive on 1/18, 1978, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
Arthur J. Wilets, Md				11/8/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
		1111-Spring St., Silver Spring, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		Jan. 21, 1979		Lee's Crematory		Washington, D.C.			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J. Wm. Lee's Sons Co.		300-4th St., NE, Wash. D.C.		20002 JAN 26 1979		Rafaela K. K...			

10-01010

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-01911	
1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) Stephen S. Bartkus						2b. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 1 7 79		2c. HOUR <input type="checkbox"/> 10 <input type="checkbox"/> 30 <input type="checkbox"/> 45 <input type="checkbox"/> PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH (MONTH DAY YEAR) 5/29/07		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT AT HOME, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FORM MOST OF WORKING HOURS) Truck Driver		12b. KIND OF BUSINESS Montgomery County	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Glen Echo		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7311 University Avenue			
14. FATHER'S NAME (FIRST MIDDLE LAST) Anthony Bartkus						15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Neva Sersevicuite					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 1927-1954		17. INFORMANT ADDRESS Alberta M. Bartkus, same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Occlusion 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) Deputy M.D. MEDICAL EXAMINER				DATE SIGNED Jan 31 1979			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				ADDRESS 7936 Old Georgetown Road Bethesda, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/11/79		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Funeral Homes; P.A. 7557 Wisconsin Avenue, Bethesda, MD				25a. DATE REC'D BY REGISTRAR JAN 16 1979				25b. REGISTRAR'S SIGNATURE [Signature]			

1110-0111

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Section

107

Montgomery

Suburban Hospital

Bedrooms

ENTRANCE

REAR PORCH

107-107

107-107

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01912 REG. NO.	
1. FOR STATE REGISTRAR						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) Margaret Amelia Barton						1. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		JAN. 4, 1915		64 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U.S.A.				MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TAKOMA PARK		WASHINGTON ADVENTIST HOSP.				SECRETARY		GOVERNMENT			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5713 SOMERSET ROAD			
MARYLAND		PRINCE GEO.		RIVERDALE							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST	
WILLIAM		JOSEPH		MOSS		AMELIA		=		FICUS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17. INFORMANT			
NO						+		579-20-1953			
								EDWARD BARTON, JR. CHEVERLY, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) bronchogenic carcinoma metastatic											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from Jan 29 , 19 79 , to Feb 29 , 19 79 , that (1) (we) last saw the deceased alive on Jan 29 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
D. J. Haidak								ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
D. J. Haidak				225 Belcrest Rd				Hyattsville			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
BURIAL				FEB. 1, 1979		FORT LINCOLN CEM.		BRENTWOOD		P.G. - MD.	
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS						FEB 5 1979		History McCreedy			
CHAMBERS FUNERAL HOME-RIVERDALE, MARYLAND											

MEDICAL CERTIFICATION

BP

100-01015

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WASHINGTON ADVISORY BOARD

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01913

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		1 - 20 - 79		5 45 P M	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		BLACK		MAR. 25, 1893		85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.		U.S.A.				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban		Retired			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Montg.		Rockville		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
PERRY DAVIS				902 Westmore Ave			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		214-18-8236		Eleanor Cooper		214 Frederick Ave Rockville MD.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Advanced cerebrovascular and systemic</u> (c) <u>atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>one week</u> <u>years</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) the hospital attended the deceased from 1/14/79 to 1/20/79, that (I) lost saw the deceased alive on 1/20/79, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Carol L. Bender MD		DEGREE MD		22c. DATE SIGNED 1/20/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR		22g. REGISTRAR'S SIGNATURE	
CAROL L. Bender, M.D.		11125 Rockville Pike, Rockville MD		JAN 26 1979		[Signature]	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		1-25-79		Elijah Cemetery		Poolesville, Montg. Md.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George R. Snowden		246 N. Wash. St. Rockville, Md.		JAN 26 1979		[Signature]	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
1208 BP

58-01013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01914 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Sadie		D				Bell		1		24		79	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		Black		2 16 12		66		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.		U.S.A.				Montgomery							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring		Holy Cross Hospital											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Montgomery		Rockville		YES <input type="checkbox"/> NO <input type="checkbox"/>		304 Frederick Avenue					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST			
Calvin		Hoy				Yelvia		Hoy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS							
NO		218-30-3529		A. D. Bell		6503 Parkway Ct. W. Hyattsville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC LIVER DISEASE 1534 DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA OF CECUM DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months 4 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
9/78		ADENOCARCINOMA OF CECUM		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/21/79 to 4/24/79, that (I) (we) last saw the deceased alive on 1-24-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and) (not) view the body after death.													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
J. A. Reiskin		M.D.		1-24-79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
J. A. Reiskin, M.D.		809 VANS MILL RD, ROCKVILLE											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		1-27-79		St. Paul Cemetery		Greenfield		Frederick		Md.			
24. FUNERAL DIRECTOR NAME		24b. N. Wash. St.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
George R. Snowden		Rockville, Md.		JAN 29 1979		J. A. Reiskin							

13-01014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01915			
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT) + Theodore Benice					14 July 24 1904							10a. M	
3 SEX male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD							
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12000 Old Georgetown Rd						
14 FATHER'S NAME FIRST MIDDLE LAST Jacob ----- (unknown)					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ettie ----- (unknown)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 105-10-8739		17. INFORMANT ADDRESS J. Lee Benice, 11403 Hook Rd., Reston, Va.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Cardiac arrest										2 hr 5.			
DUE TO, OR AS A CONSEQUENCE OF (b) acute myocardial infarction										2 hr 1.			
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease										years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/4/79 19 to 1/14/79 19, that (I) (we) last saw the deceased alive on 1/14/79 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE John A. Galotto MD DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/14/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John A. Galotto MD				22e. ADDRESS 5225 Rock Hill Rd. Bethesda Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-16-79		23c. NAME OF CEMETERY OR CREMATORY Judean Mem. Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Montgomery, Md.				
24. FUNERAL DIRECTOR NAME Lanzansky-Goldberg Mem. Chap.				25a. DATE REC'D. BY REGISTRAR JAN 18 1979				25b. REGISTRAR'S SIGNATURE [Signature]					

21010-02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01916	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) HELEN C. V. BICKEL					2a. DATE OF DEATH MONTH JAN 26 DAY 1979 YEAR			2b. HOUR 3:30 A M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH NOV 13 DAY 1896 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 		7. IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND					13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST UNKNOWN MIDDLE UNKNOWN LAST UNKNOWN					15. MOTHER'S MAIDEN NAME FIRST UNKNOWN MIDDLE UNKNOWN LAST KEENEY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 194-28-9300		17. INFORMANT SON ADDRESS KENSINGTON, MD.		17. INFORMANT CHARLES D. BICKEL, 3814 DENFIELD AVENUE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4140 Acute Congestive Heart Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 4140 Atrial Fibrillation										5 days	
(c) Coronary Artery Heart Disease											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 15, 1979 to Jan 26, 1979 , that (I) (we) last saw the deceased alive on Jan 25, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death, so state.)											
22b. SIGNATURE Robert J. Thodan DEGREE ATTENDING PHYSICIAN MEDICAL <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED Jan 26, 1979			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J. THODAN								22e. ADDRESS Rockville Rd 20852			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/29/79		23c. NAME OF CEMETERY OR CREMATORY ROLLING GREEN MEMORIAL			23d. LOCATION CITY OR TOWN PK. CAMP HILL COUNTY CUMBERLAND STATE PA		
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901								25a. DATE REC'D. BY REGISTRAR JAN 29 1979		25b. REGISTRAR'S SIGNATURE Robert J. Thodan	

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-01917
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ROBERT KENNETH BINNIX			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 24, 1979		2b. HOUR 7:50 P.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR FEB 8, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 713 HILLSBORO DRIVE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY C & P TELE.
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	
14. FATHER'S NAME FIRST MIDDLE LAST IRVIN BINNIX			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET KELLEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 214-03-9838		17. INFORMANT ADDRESS FLORENCE E. BINNIX WIFE SAME AS 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 1529 DUE TO, OR AS A CONSEQUENCE OF (b) ELECTROLYTE IMBALANCE DUE TO, OR AS A CONSEQUENCE OF (c) WIDESPREAD CARCINOMA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES DAYS 6 MO.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) PRIMARY CARCINOMA SMALL INTEL					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from DEC 10, 1978 , to JAN 24, 1979 , that (I) (we) lost saw the deceased alive on JAN 29, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard P. Delaney				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD P. DELANEY MD				22e. ADDRESS 4323 HARVARD ST SIL. SPRS MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT		23b. DATE 1/27/79		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY	
23d. LOCATION CITY OR TOWN ROCKVILLE		COUNTY MONT		STATE MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR JAN 29 1979	
ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25b. REGISTRAR'S SIGNATURE Anthony McCreedy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

18-01817

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
JANUARY 24, 1979
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]

[Illegible body text]

FRANCIS J. COLLINS
1/23/79
PARLIAMENTARY CENTER
MONT
COGNITIVE
10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01918 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Fred Leonard Bisset						2a. DATE OF DEATH MONTH DAY YEAR January 24, 1979		2b. HOUR 11:30AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr. 29, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto Tech.		12b. KIND OF BUSINESS OR INDUSTRY Mechanic	
13a. STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Derwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 19809 Muncaster Road			
14. FATHER'S NAME FIRST MIDDLE LAST David George Bisset						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Josephine Carter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO Korean		17. INFORMANT Joyce F. Bisset		17. ADDRESS Same as # 13					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Cancer Colon 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 1/12/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Colon Cancer				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 1/5 , 19 79 , to 1/24 , 19 79 , that (1) (we) lost saw the deceased alive on 23 Jan , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did not view the body after death.											
22b. SIGNATURE Lewis Keller T, MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/24/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Keller T, MD				22e. ADDRESS 1811 Prince Phillips Dr Olney, Md 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 27, 1979		23c. NAME OF CEMETERY OR CREMATORY Laytonsville				23d. LOCATION CITY OR TOWN COUNTY STATE Laytonsville Mont. Md.			
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md. 20760				24a. DATE REC'D. BY REGISTRAR JAN 29 1979		24b. REGISTRAR'S SIGNATURE [Signature]					

81010-05

Released by Dr. Ball

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01919	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Kathryn C. Black						2a. DATE OF DEATH MONTH DAY YEAR JAN. 11 1979		2b. HOUR 12:15 A.M.			
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11 28 1892		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4401 East West Highway				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4401 East West Highway			
14. FATHER'S NAME FIRST MIDDLE LAST (Unknown) Rafferty				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Mc Nally							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 139-14-0847		17. INFORMANT Kathleen Black		ADDRESS Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROBABLE ACUTE MYOCARDIAL INFARCTION 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MIN. YEARS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). RHEUMATOID ARTHRITIS, CHRONIC ANEMIA ORGANIC BRAIN SYNDROME											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6/12 1973 to 1/11 1979, that (I) (we) lost saw the deceased alive on 12/15 1978, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death.											
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-11-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Joel A. Reiskin				22e. ADDRESS 809 Viers Mill Road Rockville, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 13, 1979		23c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre		23d. LOCATION CITY OR TOWN COUNTY STATE Totowa, New Jersey					
24. FUNERAL DIRECTOR NAME Robert A. Humphrey Homes, P.A. Bethesda, Md.				25a. DATE REC'D. BY REGISTRAR JAN 16 1979		25b. REGISTRAR'S SIGNATURE [Signature]					



Robert A. Thompson, Treasurer
James P. A. Thompson, W.
Jan 15, 1970 Holy Sepulchre

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released by Medical Examiner

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01920	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Mary A Bligh						2a. DATE OF DEATH MONTH January DAY 26 YEAR 1979			2b. HOUR 730 P.M.		
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH April DAY 19 YEAR 1902		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS 		8 IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CONN.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co MD.					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY 			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 14209 GREEN SPAN LANE			
14. FATHER'S NAME FIRST JOHN MIDDLE LAST CASSIDY				15. MOTHER'S MAIDEN NAME FIRST BRIDGETTE MIDDLE LAST DOYLE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 579-60-8007		17. INFORMANT JOHNE BLIGH (SON)		ADDRESS SAME # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 DAYS	
436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS, SEVERE										10 YEARS	
(c) HYPERTENSION										10 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): UREMIA, PNEUMONITIS, LEUKOPENIA, ELECTROLYTE IMBALANCE											
19a. DATE OF OPERATION 		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9/11/75 , 19 , to present , 19 , that (I) (we) last saw the deceased alive on 1/26/79 , 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Frederick S. Caldwell						DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/27/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICK S. CALDWELL MD						22e. ADDRESS TEMPLE ROCKVILLE MD 20852					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-30-79		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON D.C.					
24. FUNERAL DIRECTOR NAME John F. DeVol ADDRESS DE VOL FUNERAL HOME WASH. DC.						25a. DATE RECEIVED BY REGISTRAR JAN 31 1979		25b. REGISTRAR'S SIGNATURE John F. DeVol			

BP

18-01250

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21203 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-01921

1. DECEASED NAME (TYPE OR PRINT) FIRST: <u>Julia</u> MIDDLE: LAST: <u>Bocci</u>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <u>Jan 8 1979</u> MATED <input type="checkbox"/> MONTH DAY YEAR		2b. HOUR OF DEATH <u>5:50 PM</u>
3. SEX <u>F</u>	4. RACE <u>W</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>Feb 2 21 1929</u>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD <u>Jan 8 1979</u>	7d. HOUR OF DEATH <u>5:50 PM</u>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Italy</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery MD</u>
10. CITY OR TOWN OF DEATH <u>Sil-Spr</u>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hosp</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <u>MD</u> 13c. CITY OR TOWN <u>Mont. Sil-Spr</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <u>3029 Red Lion Lane</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>Harry</u> <u>Catani</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Rosa</u> <u>Rapugini</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>189-01-7725D</u>		17. INFORMANT <u>Henry O'Dell</u> ADDRESS <u>3029 Red Lion Lane Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural Hematoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <u>Fell 2 ft Home</u> (b) <u>Fell 2 ft Home</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>8 days</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>None</u>					
19a. DATE OF OPERATION <u>1-3-79</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>RT Subdural Hematoma</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>11:23 1979</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <u>Fell 2 ft home with back head on furniture</u>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Home</u>	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>Red Lion Lane Sil-Spr Mont MD</u>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>John S. Rogers</u>		TITLE (SPECIFY) <u>MD</u>		MEDICAL EXAMINER <u>John S. Rogers</u>	
EXAMINER'S NAME (TYPE OR PRINT) <u>John S. Rogers</u>		ADDRESS <u>1919 Seminary Rd. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Jan. 11, 79</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Trucksville, Westmoreland, Pa.</u>
24. FUNERAL DIRECTOR NAME <u>Hines/Rinaldi</u>		ADDRESS <u>11800 New Hampshire Avenue Silver Spring, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>JAN 11 1979</u>	25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>

15810-25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01922			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
VINCENT						BONANNO		1		4	79	3 1/2	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		FEB 14, 1902		76		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
ITALY		U.S.A.				MONTGOMERY							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
SILVER SPRING		Holy Cross Hospital		SHOE REPAIRMAN									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MARYLAND		MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2604 ECCLESTON STREET					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
PLACIDO		BONANNO		ROSARIA		MUSUMEC							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		577-10-1148		SON		ROCKVILLE, MD.							
				THOMAS B. BONANNO		13102 MAGELLAN AVENUE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular failure</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1889 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinomatosis</u>												48 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of bladder</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic renal insufficiency</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 12/23, 1978, to 1/4, 1979, that (I) (we) last saw the deceased alive on 12/23, 1978, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED			
Arthur J. Willets		M.D.		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		1/4/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
ARTHUR J. WILLETS		1115 SPRING ST, SILVER SPRING, MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
BURIAL		1/5/79		GATE OF HEAVEN		SILVER SPRING		MONT		MD.			
24. FUNERAL DIRECTOR NAME		24a. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
FRANCIS J. COLLINS		500 UNIV. BLVD., W., SILVER SPRING, MD, 20901		JAN 10 1979		F. J. Collins							

BP

9071-9134

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X. CHINESE REMITS CONNECTION QUALITY

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DOCUMENT ID: A60789

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01923
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		DATE OF DEATH		HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		M	
KIMMIE BOOKER		1 26 79		12 30 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
Female	Negro	7 18 1919	59 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	
PA.	USA	WIDOWED	DIVORCED	MONTGOMERY CO	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA	SUBURBAN HOSPITAL	COOK		RESTAURANT	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
DC		DC	YES	1021 48th ST NE	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	17. INFORMANT			
FIRST MIDDLE LAST	FIRST MIDDLE LAST	ADDRESS			
JAMES D. BOOKER	COURTNEY MINOR	5805 REPPLE RD, TEMPLE HILLS, MD.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			
NO	579-40-2885	JAMES D. BOOKER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) ACUTE CARDIAC ARRHYTHMIA					
DUE TO, OR AS A CONSEQUENCE OF					
(b) RENAL DISEASE (FAILURE)					
DUE TO, OR AS A CONSEQUENCE OF					
(c) GLOMERULONEPHRITIS CHRONIC					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
RENAL DIALYSIS					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?			
1/26/79	CHRONIC RENAL DISEASE	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
	12 P.M. 1 26 1979	COLLAPSED DURING DIALYSIS			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION			
	DIALYSIS CENTER	4905 DEL RAY AVE BETHESDA MONT MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
F. C. MAYLE		DEPT		1/26/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		8200 Wisconsin Ave BETHESDA MD 20814	
F. C. MAYLE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
BURIAL	1-31-1979	FAMILY CEMETERY	ORANGE ORANGE VIRGINIA		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		FEB 5 1979		[Signature]	
W.W. CHAMBERS CO. 517 11th ST. S.E. WASH. D.C.					

33-010-23

XX

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BOOKS

LIBRARY

MONUMENT CO

SUPREMACY SOCIETY

REVEREND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01924

REG. NO.

1. FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) EVA			FIRST MIDDLE LAST BORTIN			2a DATE OF DEATH MONTH DAY YEAR January 9, 1979			2b HOUR 3:55 a.m.		
3 SEX Female			4 RACE White			5 DATE OF BIRTH MONTH DAY YEAR May 1, 1891			6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10 CITY OR TOWN OF DEATH Chevy Chase			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chevy Chase Nursing Home			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b KIND OF BUSINESS OR INDUSTRY _____		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE D.C.			13b COUNTY _____			13c CITY OR TOWN Washington			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Morris _____ Rosenblum			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie _____ Bialiaostoski			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b SOCIAL SECURITY NO. 577-46-6639		
17 INFORMANT ADDRESS Dr. Armand Gordon, 4500 Conn. Ave. NW, DC			18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: 3310 ALZHEIMER'S Disease. IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____ 1979, to _____ 1979, that (I) (we) saw the deceased alive on _____ 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b SIGNATURE H. Franz MD			22c. DATE SIGNED 1-9-79					
22d PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT KRAMER			22e ADDRESS 8630 Fenton St. S.E. SPR								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-11-79			23c NAME OF CEMETERY OR CREMATORY Adas Israel Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24 FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels, 1170 Rockville Pike			25a. DATE REC'D. BY REGISTRAR JAN 15 1979			25b. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain the certificate for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

BP

13-01851

13-01851-1

13-01851-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01925	
1- FOR Items 15, 17 g528 2/15/79 STATE REGISTRAR										REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) MARY A. BOWDEN					2a DATE OF DEATH MONTH DAY YEAR JAN 26 1979			2b HOUR 2:30 A M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 15, 1883		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS Waldron St 16 Waldron St.				
13a STATE Mass.		13b COUNTY Essex		13c. CITY OR TOWN Marblehead							
14 FATHER'S NAME FIRST MIDDLE LAST Joseph P. Graves					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Bernard						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 020-01-4245		17. INFORMATION ADDRESS Maryland Mary Louise Humphrey 4023 Oliver St. Ch.Ch.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Thoracic aortic atherosclerotic aneurysm DUE TO, OR AS A CONSEQUENCE OF (b) Diabetic melitur DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Vascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from December 19, 72 , to January 26, 1979 , that (I) (we) last saw the deceased alive on January 25, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE G. Stuart Scott					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Jan 26, 1979				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Stuart Scott, M.D.					22e ADDRESS 10401 Old Georgetown Rd. Beth., Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/27/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.					
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisc. Ave. N.E. Wash., D.C.					25a. DATE RECEIVED BY REGISTRAR'S SIGNATURE JAN 31 1979						

29-01252

MARY
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Body released by pages to Fitzgerald

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01926	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary W. Bradley						2a. DATE OF DEATH MONTH DAY YEAR 01-13-79			2b. HOUR 1:50 P.M.		
3 SEX female		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 2 26 18		6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b KIND OF BUSINESS OR INDUSTRY NIH		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN Maryland Montgomery Rockville						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5904 Vandergrift Ave.			
14 FATHER'S NAME FIRST MIDDLE LAST John Schohart				15. MOTHER'S MAIDEN NAME FIRST MIDDLE Elizabeth Unknown							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. unknown		17 INFORMANT ADDRESS Richard L. Bradley same as 13e							
18 CAUSE OF DEATH Enter only one cause per line (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>approx. 16 weeks</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/27</u> , 19 <u>78</u> , to <u>1/13</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>1/13</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) did not view the body after death, so state.)											
22b. SIGNATURE <u>J. Blaine Fitzgerald</u>						DEPUTY ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/13/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald						22e. ADDRESS Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (1597a-1)			23b. DATE 1/17/79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia			
24 FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike, Rockville, Md.						25a. DATE REC'D. BY REGISTRAR JAN 17 1979		25b. REGISTRAR'S SIGNATURE <u>Leifrey McCreedy</u>			

19-01026

01-12-79

Bradley

More

Montgomery County

Suburban Hospital

Bellevue

Montgomery County Hospital

Montgomery County Hospital

Montgomery County Hospital

Montgomery County Hospital

Montgomery County Hospital

Montgomery County Hospital

Montgomery County Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01927	
1. DECEASED NAME (TYPE OR PRINT) IRENE A. LLWINE BRADSHAW					2a. DATE OF DEATH MONTH 1 DAY 29 YEAR 79			2b. HOUR 12:30 ^{AM}			
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH 10 DAY 18 YEAR 94		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		IF UNDER 1 YEAR MONTHS 84 DAYS 84		IF UNDER 24 HRS HOURS 84 MIN. 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 503 MANSFIELD ROAD				
14. FATHER'S NAME FIRST MARTIN MIDDLE L. LAST ALLWINE					15. MOTHER'S MAIDEN NAME FIRST LAUXMAN MIDDLE LAUXMAN LAST LAUXMAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-48-8160		17. INFORMANT ROGER W. BRADSHAW		ADDRESS SAME AS 13 HUSBAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Stress Ulcer DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours 1 day 2 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Coronary Artery Disease											
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 10620 Ga. Ave. SS md		CITY OR TOWN WASHINGTON, D.C.		COUNTY D.C.		STATE D.C.	
22a. I certify that (I) (this hospital) attended the deceased from 1/15 , 19 79 , to 1/29 , 19 79 , that (I) (we) last saw the deceased alive on 1/28 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)											
22b. SIGNATURE Richard C. Cioffi		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/29/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R CIOFFI				22e. ADDRESS 10620 Ga. Ave. SS md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/1/79		23c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL		23d. LOCATION CITY OR TOWN WASHINGTON, D.C.		COUNTY D.C.		STATE D.C.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR JAN 29 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy					
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

10-01351

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
Cleared by Dr. Rogers (tel. 8 pm) 11-11-79
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01928		
1 - FOR STATE REGISTRAR					REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST OSCAR L. LEONARD BRAND					2a. DATE OF DEATH MONTH DAY YEAR 1-11-79			2b. HOUR 12:15 PM				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 11, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.						
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY PRINTING CO.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3705 BRIGHTVIEW STREET	
14. FATHER'S NAME FIRST MIDDLE LAST CARL BRAND					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA VOGT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 578-40-7188		17. INFORMANT ADDRESS HELEN D. BRAND SAME AS 13 WIFE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac - Pulmonary Failure</u> 1509 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia, Esophageal Fistula</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma Esophagus</u> 145										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pneumonia</u>												
19a. DATE OF OPERATION 12/22/78			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Esophagus				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> 19 <u>78</u> , to <u>1/10</u> 19 <u>79</u> , that (I) (yes) last saw the deceased alive on <u>1/10</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (yes) (no) (I) (did not) view the body after death.												
22b. SIGNATURE <u>Marvin L. Kockin, MD</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN L. KOCKIN					22e. ADDRESS 1015 Spring St, SS, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/13/79		23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY			23d. LOCATION WASHINGTON, D. C. COUNTY STATE				
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS					25a. DATE REC'D. BY REGISTRAR JAN 12 1979			25b. REGISTRAR'S SIGNATURE <u>Robert H. Brady</u>				
26. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901												

10-01858

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01929 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Susan Koetzle Brodell						2a. DATE OF DEATH MONTH DAY YEAR Jan. 27 1979		2b. HOUR 10 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 15 1938		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) 12512 Two Farm Drive						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12512 Two Farm Drive			
14. FATHER'S NAME FIRST MIDDLE LAST W. Lee Koetzle				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Madge H. Hurst							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 34 6611		17. INFORMANT Stephen Brodell		ADDRESS Same as above (Husband)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of breast - widespread</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic disease - Anemia - circulatory collapse</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months. 2-3 wks.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): _____											
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (a) (this hospital) attended the deceased from <u>1960</u> , 19 <u>77</u> , to <u>27 JAN</u> , 19 <u>79</u> , that (b) (I/we) last saw the deceased alive on <u>27 Jan</u> , 19 <u>77</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Ernest E. Harmon M.D.</u>		DEGREE ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 27 Jan 79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERNEST E. HARMON M.D.		22e. ADDRESS 9301 Colesville Road Silver Spring Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/30/79		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi F.H. 11800 N.H.Ave. Silver Spring, Md.						25a. DATE REC'D. BY REGISTRAR 1/31/79		25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01930
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James H Brooks, Sr.		2a. DATE OF DEATH MONTH 1 DAY 15 YEAR 79		2b. HOUR M	
3. SEX M	4. RACE Negro	5. DATE OF BIRTH MONTH May DAY 15 YEAR 19		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none	
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Hyattsville	
14. FATHER'S NAME FIRST WILLIAM MIDDLE H. LAST BROOKS		15. MOTHER'S MAIDEN NAME FIRST JEANETTE MIDDLE MITCHELL LAST MITCHELL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 228-10-6220		17. INFORMANT James H. Brooks, Jr./son/same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination DUE TO, OR AS A CONSEQUENCE OF (b) Rupture of Thoracic Aorta DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Degeneration of Aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Obstructive Pulmonary Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 6, 1976 to March 16, 1979 , that (I) (we) last saw the deceased alive on March 14, 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Howard W. Kennerly, M.D.		DEGREE M.D.		22c. DATE SIGNED 11/15/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard W. Kennerly, M.D.		22e. ADDRESS 1111 Spring St. S.W. 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-19-79		23c. NAME OF CEMETERY OR CREMATORY Rock Creek	
24. FUNERAL DIRECTOR NAME John T. Rhines Co.,		ADDRESS 3030 12th St., N.E., D.C.		25a. DATE REC'D BY REG. BUREAU JAN 22 1979	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. REGISTRAR'S SIGNATURE [Signature]			

BP

12-01030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01931 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PEGGY MNM BROOKS				2a. DATE OF DEATH MONTH DAY YEAR JANUARY 01 1979			
3. SEX FEMALE				2b. HOUR 535 A M			
4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR FEB 18 1924		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENNESSEE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA				13b. COUNTY FAIRFAX			
13c. CITY OR TOWN FALLS CHURCH				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST WALTER TIPTON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OTTIA MAY KEENE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 408 36 3615		17. INFORMANT ADDRESS ARNOLD BROOKS, 18 ETON PLACE, N.Y.-N.Y. 10709			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA 410- DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 22 JUL 19 78 , to 01 JAN 19 79 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 01 JAN 19 79 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE Tom Allen M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 01 JAN 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TOM ALLEN M.D.				22e. ADDRESS National Naval Medical Center, Bethesda, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/3/79		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON, ARLINGTON, VA	
24. FUNERAL DIRECTOR NAME MURPHYS FUNERAL HOME				25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 4 1979			
25. ADDRESS FALLS CHURCH, VA							

13210-25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01932 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Kenneth Charles Bryan						2a. DATE OF DEATH MONTH DAY YEAR Jan. 5th, 1979		2b. HOUR 1:45 M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 - 28 - 08		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3106 Farnborough Court (Home)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bricklayer		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3106 Farnborough Court			
14. FATHER'S NAME FIRST MIDDLE LAST Willard T. Bryan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Jeanette Charles							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. June 1942-Oct. '45 578-03-1362		17. INFORMANT Ella Bryan		ADDRESS Silver Spring, Md.		17b. 3106 Farnborough Ct.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOE TO, OR AS A CONSEQUENCE OF (b) Severe Coronary Artery Disease DOE TO, OR AS A CONSEQUENCE OF (c) 10 years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from March 23, 1978 , to January 5, 1979 , that (I) (we) lost saw the deceased alive on Dec. 28, 1978 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Alberto Rtosztain</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-5-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alberto Rtosztain, M.D., F.A.C.C.				22e. ADDRESS 3701 Rossmoor Blvd., Silver Spring, MD 20906							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE Jan. 8, 1979		23c. NAME OF CEMETERY OR CREMATORY Georgetown Medical School-Washington, D. C.		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME ADDRESS W. W. Chambers Co., Silver Spring, Maryland.				25a. DATE RECEIVED BY REGISTRAR JAN 11 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

12-01235

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01933 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN M. BUFF				2a. DATE OF DEATH MONTH DAY YEAR 1/10/79			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 15 48		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 411 BURNT MILLS AVENUE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS S. BLANDFORD				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA T. CARROLL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 579-60-2194		17. INFORMANT ADDRESS ERNEST BUFF SAME AS 13 HUSBAND	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of pancreas DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension, arteriosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension, arteriosclerosis							
19a. DATE OF OPERATION 12/8/78		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholelithiasis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 12/4/78 19 79 , to 1/10 19 79 , that (1) <input checked="" type="checkbox"/> I lost saw the deceased alive on above, (1) <input type="checkbox"/> (I) (did) (did not) view the body after death.							
22b. SIGNATURE H. Robert Birschbach MD				DEGREE MD		22c. DATE SIGNED 1/10/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. ROBERT BIRSCHBACH				22e. ADDRESS 10401 Old Georgetown Rd Bethesda Md 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/13/79		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PRI GEO MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25. DATE REC'D. BY REGISTRAR JAN 12 1979		25b. REGISTRAR'S SIGNATURE Robert Helms	
24. ADDRESS 500 UNIV. BLVD., W. SILVER SPRING, MD. 20901							

52-01233

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-01934	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alan Jay Bullard</i>						2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>Jan 30 1979</i>		2a. HOUR <i>3:58 PM</i>			
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Dec 24 1925</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>53 YRS.</i>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD <i>Jan 30 1979</i>		2d. HOUR <i>6:51 PM</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>WASHINGTON D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>517 Cannon Rd</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HAIR DRESSER</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>MD</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>517 Cannon Rd</i>			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ESTELLE BADANES</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>216-64-0820</i>		17. INFORMANT ADDRESS <i>SANDRA L. BULLARD 517 CANNON RD.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Stab Wound of Chest</i> <i>956-</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>None</i>											
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>2201 30 1979</i>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>2201 30 1979</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>Stabbed Self</i>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Cannon Rd Silver Spring Mont MD</i>							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Paul Rogers</i>				TITLE (SPECIFY) <i>Dep.</i>		MEDICAL EXAMINER		DATE SIGNED <i>Jan 30 1979</i>			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>FEB. 2, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>KING DAVID MEM. GDN.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>FALLS CHURCH VIRGINIA</i>					
24. FUNERAL DIRECTOR NAME <i>DONALD M. STEIN HEBREW MEMORIAL F.H.</i>				ADDRESS <i>232 CARROLL ST. N.W. D.C.</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 5 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Antony McCreedy</i>			

100-1034



Cleared by Dr. John Ball

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP
DHMH - 16 50M 7/77
(VRA 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-01935

1- FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		Jan. 3, 1979		9:30A M	
Nqrman Thomas Burke					
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	
Male	Caucasian	Oct. 15, 1907	71	YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Massachu setts	USA		Montgomery MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	10630 Montrose Dr.		Management Consultant		Property
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13b. STREET ADDRESS		
13a. STATE 13b. COUNTY		10630 Montrose Dr.			
Md. Montg.					
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Robert E. Burke		Genevieve K. Kelly			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS	
No		086-09-6757		10107 Parkwood Terrace Bethesda, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) acute myocardial infarction					unmed
410- DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart disease					years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/19/78, 19 to present, 19, that (I) we lost saw the deceased alive on 12/19, 19 78, and that in my opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Jeremy Cooke		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1/3/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Jeremy Cooke, M.D.		10400 Conn. Ave. Kensington, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation		Jan. 3, 1979	Metropolitan Crem.		Alexandria, Va.
24 FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR		
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md.			JAN 8 1979		
			25b. REGISTRAR'S SIGNATURE		
			[Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01936 REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <i>Edward Anthony Burns</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>1-5-79</i>			2b. HOUR M <i>3:20</i>				
3 SEX <i>Male</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>6-18-95</i> <i>2-22-1902</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i> <i>83</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.						
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Navy</i> Dept				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. STATE <i>Maryland</i>			13b. CITY OR TOWN <i>Montgomery</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>(unknown)</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>(unknown)</i>					16. STREET ADDRESS <i>10920 Conn. Avenue</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>none</i>		17. INFORMANT <i>Frank Buonaiuto-nephew-Greenlawn, NY</i>			ADDRESS <i>12 Kipling Dr.,</i>				
18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Respiratory failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <i>Carcinoma of lung - squamous cell</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>12/13/78</i> <i>19</i> P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from <i>1-5-79</i> to <i>1-5-79</i> , that (1) (we) lost saw the deceased alive on <i>1-5-79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>John L. Ford (md)</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>1/5/79</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOHN L. FORD</i>					22e. ADDRESS <i>344 University Blvd Silver Spring Md 20901</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>XX Burial</i>			23b. DATE <i>Jan. 8-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Sil. Spr Montgomery Md.</i>				
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i> <i>8434 Ga. Ave., S.S. Md.</i>												

10-01038

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01937 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances C Burns				2b. HOUR MIN 11:15 PM			
3 SEX Female		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR Mar. 30 1909		6. AGE (IN YEARS LAST BIRTHDAY) 69	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Casey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Boule			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-64-5944		17. INFORMANT ADDRESS (same as deceased) Edward K. Burns, Sr.-husband- 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction, right anterior cerebral</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic hypertensive cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>402-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>years</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>July</u> , 19 <u>68</u> , to <u>1-1</u> 19 <u>79</u> , that (I) <u>was</u> last saw the deceased alive on <u>7</u> <u>1-1</u> 19 <u>79</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) (did not) view the body after death.							
22b. SIGNATURE <u>Jason Reiger M.D.</u>				DEGREE M.D.		22c. DATE SIGNED 1-1-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JASON REIGER, M.D.				22e. ADDRESS 8830 CAMERON STREET SILVER SPRING, Maryland 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan, 5-1979		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Sil. Spr. Montgomery Md.	
24. FUNERAL DIRECTOR NAME Garner E. Pumphrey, Inc.				25a. DATE REC'D. BY REGISTRAR JAN 5 1979		25b. REGISTRAR'S SIGNATURE <u>Patricia McCready</u>	
24. ADDRESS 8434 Ga. Ave., S.S. Md.							

70010-02



CHIEF OF POLICE
JUL 10 1967

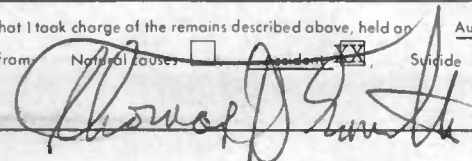



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 42 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01938
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 23 19 79										2b. HOUR M 8:30P M
1. DECEASED NAME (TYPE OR PRINT)		FIRST Timothy		MIDDLE J.		LAST Burrell						
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 22, 1953		6. AGE (IN YEARS) LAST BIRTHDAY 25 YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 1 23 19 79		2d. HOUR M 8:30P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arl. Co., Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.						
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter's Helper		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN Oakton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10165 Palmer Dr.				
14. FATHER'S NAME FIRST MIDDLE LAST Richard C. Burrell						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Beerman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 226-82-2594		17. INFORMANT Richard C. Burrell				ADDRESS same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:30xx 1 23 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) fell from roof								
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Travilah & Turkey Foot Rds. Darnestown, Mont. MD.								
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input type="checkbox"/> <u>Accident</u> <input checked="" type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/> .												
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Deputy Chief				MEDICAL EXAMINER		DATE SIGNED 1/24/79				
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		ADDRESS 111 Penn St. Balto., MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 1-26-79		23c. NAME OF CEMETERY OR CREMATORY National Memorial Pk				23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Va.				
24. FUNERAL DIRECTOR NAME Early-Wheatley 1500 W. Braddock Rd., Alex., Va.						25a. DATE RECEIVED BY REGISTRAR JAN 31 1979		25b. REGISTRAR'S SIGNATURE 				

83010-02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01939	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCIS EDWARD BYRNE, JR.					JANUARY 29, 1979					9:25 P	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR JANUARY 13, 1940			6 AGE (IN YEARS LAST BIRTHDAY) 39 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CLINICAL CENTER, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Quillen Bros			
13a. STATE DELAWARE 13b. COUNTY New Castle 13c. CITY OR TOWN WILMINGTON					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 702 FOULK ROAD				
14. FATHER'S NAME FIRST MIDDLE LAST Francis Byrne					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Veasey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 222-14-1416		17. INFORMANT ADDRESS Judith Mitchell Byrne, Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) lymphoma										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2028 } DUE TO, OR AS A CONSEQUENCE OF perforation of stomach and sepsis										72 hrs	
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (he) (this hospital) attended the deceased from DECEMBER 28, 1978, to JANUARY 29, 1979, that (he) (we) last saw the deceased alive on JANUARY 29, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.											
22b. SIGNATURE: Richard Bromer, M.D.										22c. DATE SIGNED 1/30/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Bromer										22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/2/79		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE 20014					
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR FEB 5 1979		25b. REGISTRAR'S SIGNATURE Henry McCreedy			

79-01339

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

100-100000

TO: SAC, NEW YORK (100-100000) FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR: [Illegible]

BY: [Illegible]

FOR: [Illegible]

BY: [Illegible]

FOR: [Illegible]

BY: [Illegible]

FOR: [Illegible]

BY: [Illegible]

FOR: [Illegible]

BY: [Illegible]

FOR: [Illegible]

BY: [Illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE						79-01940	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1- DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
		Adelbert		S.		Callaway	
3 SEX		4 RACE		5 DATE OF BIRTH <small>MONTH DAY YEAR</small>		6 AGE (IN YEARS) <small>LAST BIRTHDAY MONTHS DAYS HOURS MIN.</small>	
Male		Cauc.		Jan. 13, 1891		88 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Wisconsin		USA				Montgomery MD.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Bethesda		9201 Rosehill Drive				Ret. Engineer Union Carbide	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.		Montg.		Silver Spring		9829 Capitol View Dr.	
14 FATHER'S NAME <small>FIRST MIDDLE LAST</small>				15 MOTHER'S MAIDEN NAME <small>FIRST MIDDLE LAST</small>			
Samson Callaway				Emma Whittenholter			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b SOCIAL SECURITY NO.		17 INFORMANT	
Yes WW I				091-10-7547		Mary Lou Callaway Same as 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease — 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Carcinoma of ab. bladder.							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY <small>HOUR A.M. MONTH DAY YEAR P.M.</small>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		P.M. 19					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION <small>CITY OR TOWN COUNTY STATE</small>			
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE SIGNED	
John W. Ball		M.D. Deputy MEDICAL EXAMINER				Jan. 27, '79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
John G. Ball		7936 Old Georgetown Rd., Bethesda, Md.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION <small>CITY OR TOWN COUNTY STATE</small>	
Cremation		Jan. 28, 1979		Metropolitan Crem.		Alexandria Va.	
24 FUNERAL DIRECTOR (NAME ADDRESS)				25a DATE RECEIVED BY REGISTRAR (DATE REGISTRAR'S SIGNATURE)			
Robert A. Humphrey Funeral Homes, P.A. Bethesda, Md.				Feb 1 1979 Mary McCreedy			

79-01940

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01941
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
John H. CAMP		January 3 1979		1:15A M	
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	Caucasian	January 28 1919	59 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Mississippi	USA		Montgomery MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda	National Naval Medical Center	U. S. Navy-E-7	Military		
13a. STATE		13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS	
New Jersey	Atlantic	Pleasantville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	33-B Glendale Manor	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
John Abner Camp		Olga Steel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
Yes		1938-57	Harbor, N. J.		
		426 07 2634	Ida Barbetto 204 Philadelphia Ave. Egg/		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous cell carcinoma of mouth and neck</u> <u>1459</u> <u>complicated by right carotid erosion</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 6</u> 19 <u>78</u> to <u>January 3</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>January 3</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>David J. Fontayne</u> DEGREE _____				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
David J. Fontayne, D.O.				National Naval Medical Center, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		1/10/79	Arlington National		Arlington/Va.
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W.W. Chambers Co. Silver Spring, Md.		JAN 16 1979			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR Home 1/16/79 rc STATE REGISTRAR											
1 DECEASED NAME (TYPE OR PRINT) JOHN J. CAMPBELL					2a DATE OF DEATH MONTH DAY YEAR Jan 2 - 1979					2b HOUR 7 P M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 8 1895			6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive (Ret)			12b. KIND OF BUSINESS OR INDUSTRY Sales (Steel)	
13a. STATE Md. D.C.					13b. COUNTY Montgomery		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 5500 Friendship Blvd. 5101 River Road		
14 FATHER'S NAME FIRST MIDDLE LAST George W Campbell					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Leary						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 213-10-1045		17 INFORMANT Son John J. Campbell, Same as item 13.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>485- Bronchopneumonia, Bilateral</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Generalized Arteriosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 1978</u> years, 19 <u>78</u> to <u>Jan 2</u> 19 <u>79</u> , that (we) lost saw the deceased alive on <u>Dec 1978</u> , and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>James W. Egan</u>					DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/2/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES W. EGAN					22e. ADDRESS 5413 Cedar Ln Bethesda, Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/6/1979		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn, New York			
24. FUNERAL DIRECTOR NAME JOSEPH CAWLER'S SONS INC. 6130 WISG. AVE., N. W. WASH., D. C. 20016					25a. DATE REC'D. BY REGISTRAR JAN 8 1979			25b. REGISTRAR'S SIGNATURE Lefkey McCreedy			

78-01345

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01943	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Agnes Stansbury Cann						2a. DATE OF DEATH MONTH DAY YEAR January 3, 1979			2b. HOUR 8:00 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 21, 1884		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 94 84		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Asbury Village			
14. FATHER'S NAME FIRST MIDDLE LAST Alpheus Stansbury						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda Hodges					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-18-2696		17. INFORMANT ADDRESS Mrs. Ethel Rainey Mass.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C. H. F. Acute Chl. 4140 DUE TO, OR AS A CONSEQUENCE OF (b) A. S. I. D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days ?											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Acute Atk. M. I. - Dec. 10, 1978											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from June 19, 77, to 1-3, 1979, that (I) (we) lost saw the deceased alive on 1-3-79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jack Schumacher M.D.						DEGREE M.D.		22c. DATE SIGNED 1-4-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacher, M.D.						22e. ADDRESS Montgomery County General Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/6/79		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Md.					
24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co. NAME ADDRESS 4905 York Rd. Balto., Md. 21212						25a. DATE REC'D. BY REGISTRAR JAN 5 1979		25b. REGISTRAR'S SIGNATURE Rafael McCreedy			

79-01313

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01944 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Milbourne E. Carter				2a. DATE OF DEATH MONTH DAY YEAR January 23, 1979			
3 SEX Male				4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 1, 1896	
6 AGE (IN YEARS LAST BIRTHDAY) 83		7. IF UNDER 1 YEAR MONTHS DAYS YRS.		8. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Carpenter	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington	
14. FATHER'S NAME FIRST MIDDLE LAST Richard Carter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Carter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579 01 6024		17. INFORMANT ADDRESS #1 Dorothy C. Thompson Biglerville, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PROSTATIC CANCER</u> 185- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 YEARS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) did not attended the deceased from <u>9 DEC</u> , 19 <u>78</u> , to <u>23 JAN</u> , 19 <u>79</u> , that (I) lost saw the deceased alive on <u>18 JAN</u> , 19 <u>79</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) do not (did not) view the body after death.							
22b. SIGNATURE <u>Walter E. Goodth MD</u> DEGREE 22c. DATE SIGNED <u>24 JAN 79</u>				22d. ADDRESS <u>2309 SHOREFIELD RD WHEATON MD</u>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOODTH MD		22f. ADDRESS 2309 SHOREFIELD RD WHEATON MD		22g. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/26/79		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg, Maryland	
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Rockville, Md.				25a. DATE REC'D. BY REGISTRAR JAN 30 1979		25b. REGISTRAR'S SIGNATURE <u>Rita J. Kelly</u>	

19-01844

JAN 20 1979

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Item #10a Film G530 4/3/79 re		STATE OF MARYLAND		79-01945	
1. FOR STATE REGISTRAR		Items 18a. & 18b. & 18c.		DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
Film#G532 6-14-79 as		CERTIFICATE OF DEATH		REG. NO. J R 80790	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR		
Abbe Deanna CATO			January 11 1979		
3. SEX			4. RACE		
Female			Negro		
5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		
December 21 1978			21		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		
Maryland			USA		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		
Bethesda			National Naval Medical Center		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
N/A			MD.		
13a. STATE			13b. CITY OR TOWN		
D. C.			Bolling Air		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
William T. Cato			Carrie Davis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
N/A			N/A		
17. INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Promaturity</u>		
William T. Cato See Item 13			Diffuse intralveolar hemorrhage, left lung		
			DEFERRED pending results of microscopic examination		
			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks		
			DUE TO, OR AS A CONSEQUENCE OF (b) <u>gangrenous necrosis of lower extremities secondary to arterial thrombembolism</u>		
			DUE TO, OR AS A CONSEQUENCE OF (c) <u>acute tubular necrosis</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I/ (this hospital) attended the deceased from <u>Dec. 21</u> 19 <u>78</u> , to <u>Jan. 11</u> 19 <u>79</u> , that I/ (we) lost saw the deceased alive on <u>Jan. 11</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/ we) (did) (did not) view the body after death.					
22b. SIGNATURE DEGREE				22c. DATE SIGNED	
Stanley Spewack, LCDR.				1/13/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
Stanley Spewack, LCDR				National Naval Medical Center, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		15 Jan 79		Arlington National	
24. FUNERAL DIRECTOR		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE	
Marshall's Funeral Home, Inc.		JAN 17 1979			
4217 - 9th Street NW, Washington, D.C.					

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01946 REG. NO.					
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR										
Aldo F. Cervi					1-17-79 9:55 PM										
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
Male			Caucasian		09/07/08			70							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Pennsylvania			U.S.A.					Montgomery MD.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Suburban Hospital							Painter			Painting		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6811 Fairfax Drive			
14. FATHER'S NAME FIRST MIDDLE LAST										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Erminio Cervi										Anna Pastarine					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS								
No					172-12-0380A		Fay B. Cervi, same as #13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
1629 hypoxia and myocardial infarction post															
DUE TO, OR AS A CONSEQUENCE OF (b)															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
1-9-79										Carcinoma left lower lobe lung		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
					P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1-2-79, to 1-17-79, that (I) (we) last saw the deceased alive on 1-17-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE		22c. DATE SIGNED			
										V.C. DeGuzman MD		1-18-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS					
V.C. DE GUZMAN MD										1234 15 NW WASH DC					
23a. BURIAL, CREMATION, REMOVAL (REMARKS)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial			01/20/79		Westmoreland Memorial Park			Hempfield, PENNA							
24. FUNERAL HOME										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey Funeral Homes, P.O. 7557 Wisconsin Ave., Bethesda, MD										JAN 24 1979		[Signature]			

8-010108

IV

RECEIVED

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JAN 21 1968

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-01947			
1. DECEASED NAME (TYPE OR PRINT) C. KAY CHACONAS										2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> Jan 25, 79										2b. HOUR A. M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 8, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Jan. 25, 19 79										2d. HOUR 4P M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.											
10. CITY OR TOWN OF DEATH Chevy Chase				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4701 Willard Ave.,								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Adm. Ass't. G.A.O.				12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4701 Willard Ave.,															
14. FATHER'S NAME FIRST MIDDLE LAST Louis Chaconas										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Skiados													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578-01-5724				17. INFORMANT ADDRESS Wash., D.C. Stephen L. Chaconas 2718 Poplar St. N.W.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Disease</u> 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- } lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <u>John G. Ball</u>				TITLE (SPECIFY) M.D. <u>Dr. Puty</u>				MEDICAL EXAMINER				DATE SIGNED Jan 25, 1979											
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball				ADDRESS 7936 Old Georgetown Rd., Bethesda, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment				23b. DATE 1/29/79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Mausoleum				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Md.													
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C.										25a. DATE REC'D. BY REGISTRAR JAN 31 1979				25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>									

70-01047

Information received from the Lincoln Institute, Newark, N.J.
Joseph Davidson, born [redacted]
8130 Loc. Ave. N.E., Seattle, W.A.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-01948

1- STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
FIRST MIDDLE LAST		5. DATE OF BIRTH		6. AGE (IN YEARS)	
Bronna Chaïmson		F W June 14 30		48 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Wisconsin		U.S.A.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Silver Spring Md		Holy Cross Hospital		HOUSEWIFE	
13a. STATE		13b. COUNTY		13c. STREET ADDRESS	
Md		Mont. Co		10307 Ridgeman Dr	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		17. INFORMANT ADDRESS	
LOUIS - GREENE		SARAH - KALMAN		391-24-4114 NATHAN CHAIMSON SEE #13	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		18b. SOCIAL SECURITY NO.		18c. INFORMANT ADDRESS	
NO		391-24-4114		NATHAN CHAIMSON SEE #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Acute and Chronic Alcoholism</u>					
303- DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
[Signature]		M.D. Daps		JAN 26 1979	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
CREMATION		1/26/79		CEDAR HILL CREM.	
23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
SUITLAND		PG		MD	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
W.W. CHAMBERS CO		SILVER SPRING, MD		JAN 29 1979	
25b. REGISTRAR'S SIGNATURE					
[Signature]					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT MUST BE EXECUTED WITHIN 72 HOURS. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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44245214

March 1975

2012 - Present - ZARAH - KATHARINE
2013 - 2014 - ZARAH - KATHARINE

Wm. G. M. Co. 2125 Broadway
Greenwich Village New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01949 REG. NO.		
1. FOR STATE REGISTRAR					2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)					Frederick John Chaney			January 8, 1979			1:00PM	
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		January 24, 1906			72		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Baltimore Md.		U.S.A.					Montgomery County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Olney		Montgomery General Hospital					Retired clerk		Court			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland		Howard		Ellicott City		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3429 Pierce Drive				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME							
late Edward					late Anna							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No					212 10 4959		Mrs Dorothy Chaney 3429 Pierce Dr. 21043					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>										3 days		
410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u>										years		
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
			HOUR A.M. MONTH DAY YEAR									
			P.M. 19									
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 5, 1979</u> to <u>Jan 8, 1979</u> , that (I) (we) last saw the deceased alive on <u>Jan 7, 1979</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE					DEGREE			22c. DATE SIGNED				
<u>Margaret S. Choa, MD</u>								1-8-79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS							
MARGARET S. CHOA, MD					1111 Spring St, Silver Spring, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION				
Burial			Jan 11, 1979		Woodlawn			CITY OR TOWN COUNTY STATE				
								Woodlawn, Balto. Maryl and 20918				
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Harry H. Witzke 4112 Columbia Rd Ellicott City					JAN 11 1979			<u>Robert M. Brady</u>				

BP

1a-0104a

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01950 REG. NO.	
1. FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
		SARAH CHERRNAV				January 7, 1979				7:09 AM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		June 6, 1896		82		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Russia		U. S. A.				Montgomery MD					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Silver Spring		HOLY CROSS HOSPITAL				Merchant		Retired			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1023 Devere Drive			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
Max Zeenkov				Rachel Anthony							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
No		097-03-4195		Alvin Cherrnav		Same as No. 13					
18 CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 10a. <u>Acute Cerebrovascular Accident (Stroke)</u>											
436- DUE TO, OR AS A CONSEQUENCE OF <u>Hypertension</u>											
Conditions, if any, which gave rise to immediate cause 10a, stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF <u>C</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10a. <u>Diabetes Mellitus; CNP; Neg</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED		21d INJURY OCCURRED					
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					
21f. LOCATION		CITY OR TOWN		COUNTY		STATE					
22a I certify that (this hospital) attended the deceased from <u>1977</u> , 19 <u>59</u> , to <u>Jan 7</u> , 19 <u>79</u> , that (we) last saw the deceased alive on <u>Jan 7</u> , 19 <u>59</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)		22b SIGNATURE		DEGREE		22c DATE SIGNED					
Charles Franklin, M. D.		MD		1-8-79							
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS									
Charles Franklin, M. D.		11200 Lockwood Drive, Silver Spring, Md.									
23a BURIAL, CREMATION, REMOVAL		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		23e COUNTY			
Burial		1/10/1979		New Montifiore Cemetery		Pinelawn, L. I., New York					
24 FUNERAL DIRECTOR		24a NAME		24b ADDRESS		24c DATE RECEIVED BY REGISTRAR		24d REGISTRAR'S SIGNATURE			
232 Carroll Street, N. W.		Donald M. Stein		Hebrew Memorial F.H.		JAN 16 1979					

10-01220

10-01220

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01951

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR		
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN		
Irma Y ⁱ Chia		January 24, 1979		11: A ^M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		
Female	Oriental	MONTH DAY YEAR	59 YRS.	IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
Peru	Peru		Montgomery MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville	5201 Brentford Drive		Housewife			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
STATE	COUNTY	CITY OR TOWN	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	5201 Brentford Drive		
Maryland	Montgomery	Rockville				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST		FIRST MIDDLE LAST				
Ezequiel Y ⁱ		Valentina Sanchez				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No		None		Sonia Bell 5201 Brentford Drive		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 Metastatic Adenocarcinoma (4-78) DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from January 11 1979 to January 24 1979, that (I) (we) lost the deceased alive on January 11 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE		22c. DATE SIGNED		
Richard W. Holt M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
Richard W. Holt, M.D.		3800 Reservoir Rd., N.W. Wash, D.C.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial	1/26/79	Gate of Heaven Cem.	Silver Spring, Md.			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Tyson Wheeler Funeral Home, Inc. Rockville, Md.		JAN 30 1979				

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-01952 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William Thomas Clark</i>						2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <i>Jan 19 1979</i>		2b. DATE OF DEATH MONTH DAY YEAR <i>Jan 25 1979</i>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>Jan 25 1979</i>	
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 6. 27 51</i>		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. <i>28 YRS.</i>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington D C</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U S A</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>	
10. CITY OR TOWN OF DEATH <i>Wash. D.C.</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Wash. D.C. Advant Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>TRUCK DRIVER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>OTL CO.</i>	
13a. STATE <i>MD</i>						13b. COUNTY <i>Georgetown</i>		13c. CITY OR TOWN <i>Hyattsville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>EVERETT R CLARK</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>DOLORES BRODERICK</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>YES</i>				16b. SOCIAL SECURITY NO. <i>577 32 8324A</i>		17. INFORMANT ADDRESS <i>DOLORES C CLARK HYATTSVILLE, MD</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <i>Chronic Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Yrs.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>John G Rogers</i>				TITLE (SPECIFY) <i>MD</i>				MEDICAL EXAMINER <i>Silver Springs, Md.</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>John G Rogers</i>				ADDRESS <i>Silver Springs, Md.</i>				DATE <i>Jan 26, 1979</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>Jan 29, 1979</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Springs Montgomery Md</i>			
24. FUNERAL DIRECTOR NAME <i>F. Gasch's Sons P A Hyattsville, Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>JAN 30 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Robert K. Roberts</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-01953
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Elsie May Clements</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1-12-79</i>			2b. HOUR <i>8 12 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11-2-17</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>61</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery Cnty. Md.</i>	
10. CITY OR TOWN OF DEATH <i>Takoma Pk.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
13a. STATE <i>Maryland</i>				13b. CITY OR TOWN <i>Pr. Georges Adelphi</i>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Porter Ricketts Ricketts</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Grace Sourwine</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>579-48-7918</i>		17. INFORMANT ADDRESS <i>Arthur E. Clements-husband-(same as 13c)</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiogenic Shock</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>few hours</i> <i>4280</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>few weeks</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>COA = Left Hemiparesis</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1/3</i> 19 <i>79</i> , to <i>1/12</i> 19 <i>79</i> , that (I) lost lost saw the deceased alive on <i>1/12</i> 19 <i>79</i> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (If true) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Antonio G. Uy</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1-12-1979</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ANTONIO G. UY</i>		22e. ADDRESS <i>831 University Blvd E. #23 Silver Spring, Md. 20903</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Jan. 16-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood Pr. Georges Md.</i>	
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		ADDRESS <i>8434 Ga. Ave., S.S. Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 18 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Anthony M. Brady</i>	

BP

72-010-07

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-01954

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
Michael Joshua Cohen							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR
Male	White	12/12/07	71 YRS.			1/20/79	3:38PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	WIDOWED	DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland	U. S. A.					Montgomery MD.	
10. PLACE OF BIRTH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park	Washington Adventist Hosp.	Sales		Hardware			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland		Mont	S.S.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	916 Univ. Blvd. E.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT	
Max		Cohen		Ida		Miller	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		577-07-8010		Mrs. Sadie Cohen		Same as No. 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u>							
4291							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>Chronic Myocardial Dis.</u>						Yrs.	
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?			
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)		DATE SIGNED			
ACTUAL SIGNATURE <u>John Rogers, M.D.</u>		MEDICAL EXAMINER		JAN 20 1979			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		1919 Seminary Rd., Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		1/22/1979		Judean Memorial Gardens		Olney, Maryland	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Donald M. Stein		Hebrew Memorial F.H.		JAN 24 1979		Barry K. Brown	
232 Carroll Street, N. W.		Washington, D. C.					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT SHOULD BE EXECUTED WITHIN 72 HOURS. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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Michael Joseph C. ...

12/12/71

White

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Tokyo, Japan

Washington, D.C.

10/10/71

216 Univ. Blvd. E.

S.S.

10/10/71

John Rogers, M.D.

1010 Seminary Rd., Silver Spring, Md.

No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for cases.

MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-01955 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) WILLIAM A. COLLINS JR.			2a. DATE OF DEATH MONTH DAY YEAR January 9, 1979		2b. HOUR 8.50 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 1 11		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 67	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. BLDG. INSPECTOR MONTG. CO.		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Maryland Mont		13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13803 Parkland Dr.
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM A. COLLINS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY HENLEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WWII		16b. SOCIAL SECURITY NO. 218-07-1329	17. INFORMANT ADDRESS WM. A. COLLINS III 17703 LOCHNESS CR., 20832 OLNEY, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inter ventricular Cerebral Bleed 431- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/8 , 19 79 , to 1/9 , 19 79 , that (I) (we) last saw the deceased alive on 1/9 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. Schuman		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/10/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joel Schuman		22e. ADDRESS BETHESDA, MD. 9410 Old Georgetown Road			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-13-79	23c. NAME OF CEMETERY OR CREMATORY PARKLAWN MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONTGOMERY MD.
24. FUNERAL DIRECTOR NAME ADDRESS ROBERT A. PUMPHREY FUNERAL HOMES P/A MD. ROCKVILLE		25a. DATE REC'D. BY REGISTRAR JAN 18 1979		25b. REGISTRAR'S SIGNATURE Jeffrey McCready	

22010-05

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01956

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WYNONA E. COLLINS			2a. DATE OF DEATH MONTH DAY YEAR 1-16-79			2b. HOUR 3:40 AM			
3 SEX FEMALE		4 RACE NEGROID		5. DATE OF BIRTH MONTH DAY YEAR 8-19-1900		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JAMES ROGER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO.			17. INFORMANT JAMES MOORE			ADDRESS 13205 CLIFTON RD. SILVER SPRING, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEPATIC FAILURE 1519 DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA OF STOMACH DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death 10 DAYS MONTHS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HYPERSPLENISM, THROMBOCYTOPENIA, CONGESTIVE HEART FAILURE									
19a. DATE OF OPERATION N.A.		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N.A.			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> N.A. NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> N.A.		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N.A.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N.A.					
22a. I certify that (this hospital) attended the deceased from DECEMBER 11, 1978 , to JANUARY 16, 1979 , that (I/we) last saw the deceased alive on JANUARY 16, 1979 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.									
22b. SIGNATURE John A. Balacki				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED January 16, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN A. BALACKI				22e. ADDRESS 1109 SPRING ST. SILVER SPRING, MD. 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/20/79		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.			
24. FUNERAL DIRECTOR NAME BAILEY'S FUN' HOME				ADDRESS 1346 CALHOUN ST.		25a. DATE REC'D. BY REGISTRAR JAN 19 1979		25b. REGISTRAR'S SIGNATURE Ruthy McCreedy	

1401
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1401

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

79-01926

FEMALE
U.S.A.

MA
Buro



NOT TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE RETURN THE COMPLETED CERTIFICATE TO THE JURY CLERK OF THE DISTRICT COURT FOR BALTIMORE COUNTY. **TO FUNERAL DIRECTOR:** PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. BELMONT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-01957																																																	
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH MATED										2b. HOUR																																																	
Paul A. Conlin										1 13 1979										1 13 1979																																																	
3. SEX Male										4. RACE White										5. DATE OF BIRTH Sept 15 1907										6. AGE (IN YEARS) 71 YRS.										7. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED NEVER MARRIED WIDOWED										9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co									
10. CITY OR TOWN OF DEATH Bethesda										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Suburban Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Editor										12b. KIND OF BUSINESS OR INDUSTRY Magazine																																							
13a. STATE D.C.										13b. COUNTY 13c. CITY OR TOWN Washington										13d. INSIDE CITY LIMITS? YES NO										13e. STREET ADDRESS 3506--"O" St., N.W.																																							
14. FATHER'S NAME Peter A. Conlin										15. MOTHER'S MAIDEN NAME Winifred McHugh										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes WW1										16b. SOCIAL SECURITY NO. 578-09-9789										17. INFORMANT Daughter Ann Mooers, 10024 Kendale Rd., Potomac, Md																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Dis. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None																																																																					
19a. DATE OF OPERATION None										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES NO																																																	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																																	
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																																																	
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner																																																																					
ACTUAL SIGNATURE John Rogers, M.D.										TITLE (SPECIFY) M.D. Dec.										DATE SIGNED Jan 13 1979																																																	
EXAMINER'S NAME (TYPE OR PRINT) John Rogers, M.D.										ADDRESS 1919 Seminary Rd., Silver Spring, Md.																																																											
23a. BURIAL CREMATION REMOVAL (SPECIFY) Burial										23b. DATE 1/16/1979										23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery										23d. LOCATION CITY OR TOWN COUNTY STATE Ft. Meyer, Virginia																																							
24. FUNERAL DIRECTOR NAME JOSEPH CAWLER'S SONS INC. 5120 WISG. AVE., N. W. WASH., D. C. 20016										25a. DATE REC'D BY REGISTRAR JAN 16 1979										25b. REGISTRAR'S SIGNATURE J. S. Brady																																																	

79-01927

Montgomery Co

XX

Suburban Hospital

Frederick

Frederick

Frederick

79-01927

II

Frederick

Frederick, Md. 21701

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01958

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mabel Thomas Copland			2a. DATE OF DEATH MONTH DAY YEAR 1/22/79			2b. HOUR 8 P.			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 23, 1910		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH S.S.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U S Gov't		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Roby S. Thomas			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Holt			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No			
16b. SOCIAL SECURITY NO. 579 40 1234			17. INFORMANT 103 High Rock St. Needham, Mass. Florence T. Johnson (Sister)						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Leukosarcoma of uterus 1892 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/5 19 79 , to 1/22 19 79 , that (I) (we) last saw the deceased alive on 1/5 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Marvin Fuchs DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 1/22/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN FUCHS						22e. ADDRESS 5315 Connecticut Ave Wash DC 20015			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 1/23/79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory Brentwood, PG.		23d. LOCATION CITY OR TOWN COUNTY STATE Md.		
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H. 11800 N.H.Ave. S.S. Md						25. DATE RECD. BY REGISTRAR JAN 24 1979		25b. REGISTRAR'S SIGNATURE Luttrell	

MEDICAL CERTIFICATION

99

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1402

BP

79-01228

Thomas	White	Oct. 18, 1910	48
USA	Montgomery		
2.8.	Cavallaro Hill Meeting House	U S Gov't	
Ms.	Mont.	2.8.	X
	14905 New Hampshire Ave.		
Ruby E. Thomas	Sarah Hale		
	105 High Rock St. Needham, Mass.		
579 45 1234 Florence T. Johnson (Sister)			

1/23/79
 11800 R.R. Ave. S.E. 4th St. S.E.
 1/23/79
 11800 R.R. Ave. S.E. 4th St. S.E.
 1/23/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01959
REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ANN K. CORRADO		2a. DATE OF DEATH MONTH DAY YEAR JAN. 31, 1979		2b. HOUR 8:30 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 16, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse		12b. KIND OF BUSINESS OR INDUSTRY Dr's. Office			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda	
14. FATHER'S NAME FIRST MIDDLE LAST Peter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Wailmeyer		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-07-1811		17. INFORMANT Son ADDRESS Frank L. Corrado, Jr. Same as item 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) RESPIRATORY FAILURE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 DAYS	
DUE TO, OR AS A CONSEQUENCE OF (b) INTRACRANIAL HEMORRHAGE				28 DAYS	
DUE TO, OR AS A CONSEQUENCE OF (c) RUPTURED BERRY ANEURYSM				28 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION JAN. 20, '79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RUPTURED ANEURYSM (CEREBRAL)		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JAN 3, 1979 , to JAN 31, 1979 , that (I) have last saw the deceased alive on JAN. 30 19 79 and that in (my) low opinion death occurred on the date and hour and from the causes stated above, (I) have did not view the body after death.					
22b. SIGNATURE Joseph Connor, MD		DEGREE MD		22c. DATE SIGNED 31 JAN 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Connor, MD.		22e. ADDRESS 9420 Old Georgetown Rd. - Bethesda, Md 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/3/1979		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	
23d. LOCATION CITY OR TOWN Silver Spring COUNTY Maryland STATE					
24. FUNERAL DIRECTOR NAME JOSEPH GAWLER'S SONS INC.		ADDRESS 5130 WISC. AVE., N. W. WASH., D. C. 20018		25a. DATE REC'D BY REGISTRAR FEB 1 1979	
				25b. REGISTRAR'S SIGNATURE Anthony McCready	

MEDICAL CERTIFICATION

BP

79-01259

Female	White	Nov. 16, 1911	67
Virginia	U.S.A.	x	
Montgomery	Section 16	Hospital	Registered Nurse Dr. G. L. G. L.
9200 Michigan Ave			
John P. P. P.	Kellogg	John P. P. P.	
10	275-01-1811	Frank I. G. L. G. L.	Same as item 11.

Expiry Date of license 2/3/1915 Date of license 2/3/1915

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-01960			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
DONNA A COWDEN				11/24/79 1:40 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Fe.		WHITE		11 18 06		72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MISSOURI		USA				MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		CARRIAGE HILL		GOVT		SECY	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
MD				MONTGOMERY		BETHESDA	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
NOT KNOWN				NOT KNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
No		491-09-240		MARY Bly. SAME AS ITEMS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 1539 Respiratory Arrest							
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Colon Cancer							
DUE TO, OR AS A CONSEQUENCE OF (c) Seizure & Stroke							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 29 19 78, to Jan. 24 19 79, that (I) (we) lost saw the deceased alive on Jan 24 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) know the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		1/24/79			
Boo K. Kim		19261 Mont Village Ave, Faith, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Removal		Jan 24 79		Georgetown Md Sch		Wash, D.C.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W.B. Chambers		8655 Saw Ave. S.S. Md.		JAN 29 1979			

BP

03010-07

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-01961 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Gardner Livingston Cregger Gardner Cregger		2a. DATE OF DEATH MONTH DAY YEAR 1-31-79		2b. HOUR 9:10p M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 31, 1910	
6. AGE (IN YEARS (LAST BIRTHDAY)) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor	
12b. KIND OF BUSINESS OR INDUSTRY Construction		13a. STREET ADDRESS 20240 Frederick Road		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Miller - Cregger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie - Fulcher		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no	
17. SOCIAL SECURITY NO. 226-30-3853		18. INFORMANT Ovella C. Ayers		19. ADDRESS Rockville, Md. 5108 Macon Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST 7423 DUE TO, OR AS A CONSEQUENCE OF (b) increased intracranial pressure & brain stem infarct DUE TO, OR AS A CONSEQUENCE OF (c) Dandy-Walker posterior fossa cyst & hydrocephalus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several hours		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 19a. DATE OF OPERATION 1/11/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Dandy-Walker cyst	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNOERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 12/23 1978 to 1/31 1979, that (I) (we) lost saw the deceased alive on 1/31 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE Bernard Topak MD		22c. DATE SIGNED 2/1/79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD TOPAK MD	
22e. ADDRESS 5554 Wilshire Ave. Cl. Cl. Md.		23a. NAME OF CEMETERY OR CREMATORY Zion Cemetery		23b. DATE Feb. 5, 1979	
23c. LOCATION CITY OR TOWN COUNTY STATE Nebo Smyth Virginia		23d. NAME OF CEMETERY OR CREMATORY (SPECIFY) Removal-Burial		23e. DATE Feb. 5, 1979	
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md. 20760		25a. DATE REC'D. BY REGISTRAR FEB 5 1979		25b. REGISTRAR'S SIGNATURE L. H. H. H.	

10010-02

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01962
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Megan		2a. DATE OF DEATH MONTH DAY YEAR 1/13/79		2b. HOUR 12:25A M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 13 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) --		12b. KIND OF BUSINESS OR INDUSTRY --			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG	
14. FATHER'S NAME FIRST MIDDLE LAST Gary Denver Cross		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dianne Carla Jones		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NO		17. INFORMANT ADDRESS GARY CROSS, SAME AS 13 FATHER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Not able to Breathe 7689 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Esfand Nawab, D.</i>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Esfand Nawab,		22e. ADDRESS 10401 Old Georgetown Rd. Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/17/79		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN	
23d. LOCATION CITY OR TOWN COUNTY SILVER SPRING MONT MD.					
24. FUNERAL DIRECTOR FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR JAN 19 1979		25b. REGISTRAR'S SIGNATURE <i>Barry McBrady</i>	

12-01005

241

11/17/79

5/5/5

2. *Staphylococcus aureus*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-01963 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST David E Cullen			2a. DATE OF DEATH MONTH DAY YEAR 1 15 79		2b. HOUR 12 10 AM
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR Dec. 25 1895		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Processing	
13a. STATE Md.		13b. CITY OR TOWN Bethesda		13c. STREET ADDRESS 4400 Chestnut Street	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 476-14-6118		17. INFORMANT Mrs. Kathleen M. Summa (Same as 13c)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Tumor, RIGHT LUNG. 2391 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JAN 3 1979 to JAN 15 1979, that (I) (we) lost saw the deceased alive on JAN. 15 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Leo M. Curtis		DEGREE M.D.		22c. DATE SIGNED 1-15-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEO M. CURTIS, M.D.		22e. ADDRESS 8218 WISCONSIN AVE, BETHESDA, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-22-79		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem. Mendota Minn.	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Md.		25a. DATE RECEIVED BY REGISTRAR JAN 22 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

10-01003

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01964
REG. NO.

1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST JUNE	MIDDLE Cunningham	LAST Cunningham	2a. DATE OF DEATH	MONTH Jan.	DAY 22	YEAR 1979	2b. HOUR 6:55 PM
3. SEX F.	4. RACE Caucasian	5. DATE OF BIRTH MONTH June	DAY 9	YEAR 1935	6. AGE (IN YEARS LAST BIRTHDAY) 43	YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Un Employed		12b. KIND OF BUSINESS OR INDUSTRY Secy.		MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Un Employed		12d. KIND OF BUSINESS OR INDUSTRY Secy.						
13a. STATE MD.		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9215 Barclon Road			
14. FATHER'S NAME FIRST Edward		MIDDLE Prilliman		LAST Prilliman		15. MOTHER'S MAIDEN NAME FIRST Eva		MIDDLE Marie		LAST Rice	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Unknown		17. INFORMANT Wayne H. Prilliman		ADDRESS 7382 Colton Lane Manassas Virginia					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 1990 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. b) <u>Carcinoma disseminated</u> c) <u>intra-pulmonary, etiology uncertain</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Carcinoma of pharynx</u>											
19a. DATE OF OPERATION 12/11/78		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>12/2/78</u> , 19 <u> </u> , to <u>1/22/79</u> , 19 <u> </u> , that (we) lost saw the deceased alive on <u>1/22/79</u> , 19 <u> </u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>H. Robert Birschbach</u>						DEGREE <u>MD</u>		22c. DATE SIGNED 1/22/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Robert Birschbach						22e. ADDRESS 10401 Old Georgetown Rd. Bethesda					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/26/79		23c. NAME OF CEMETERY OR CREMATORY Hollywood Bapt Cem		23d. LOCATION CITY OR TOWN COUNTY STATE		Chatham Virginia			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Rockville, Md.						25a. DATE REC'D. BY REGISTRAR JAN 30 1979		25b. REGISTRAR'S SIGNATURE <u>Robert H. Berry</u>			

78-01864

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01965 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harold Daniels						2a. DATE OF DEATH MONTH DAY YEAR 1 7 - 79		2b. HOUR 2:05 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 9 1909		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wyoming		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dist. Mgr.		12b. KIND OF BUSINESS OR INDUSTRY Food Ind.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13e. STREET ADDRESS 3400 Parker Creek Lane					
14. FATHER'S NAME FIRST MIDDLE LAST David - Daniels				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane - Stellars							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-22-1044		17. INFORMANT Vernetta Daniels		ADDRESS 3400 Parker Creek Lane Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF: (b) Cerebral Vascular Thrombosis DUE TO, OR AS A CONSEQUENCE OF: (c) Arteriosclerotic Cerebrovascular Dis. 4+ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. 4340											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cancer of Colon Arteriosclerotic Heart Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5-7-78 19 to 1/7/79 19, that (I) (we) last saw the deceased alive on 1/7/79 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Jeremy Blouke				DEGREE Attending Physician		22c. DATE SIGNED 1/7/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeremy Blouke				22e. ADDRESS 10400 Penn Ave Kensington							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/11/79		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mo. Md.					
24. FUNERAL DIRECTOR NAME Hines/Rinaldi		11800 New Hampshire Ave., Silver Spring, Md. 20904		25a. DATE REC'D. BY REGISTRAR JAN 9 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy					

MEDICAL CERTIFICATION

99

6000

20010-02

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-01966	
1. DECEASED NAME (TYPE OR PRINT) Don Elroy Davis						2a. DATE KNOWN OF DEATH ESTIMATED Jan 7 1979		2b. HOUR pm			
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH Aug DAY 15 YEAR 1961	6. AGE (IN YEARS) LAST BIRTHDAY 61 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 	2c. DATE PRONOUNCED DEAD Jan 9 1979		2d. HOUR pm			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> SEPARATED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Rock Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7106 Poplar Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN (RET)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY Montg.		13c. CITY OR TOWN Rock Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7106 Poplar Ave.			
14. FATHER'S NAME FIRST MERL MIDDLE L. LAST DAVIS				15. MOTHER'S MAIDEN NAME FIRST NELLIE MIDDLE LAST SAXTON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. W.W.2 + KOREAN 577-12-5522		17. INFORMANT ADDRESS DAISY LORETTA DAVIS, 11606 IDLEWOOD RD S.S. MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute & Chronic Alcoholism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. 303- (b) DUE TO, OR AS A CONSEQUENCE OF (c) 											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John P. Rogers				TITLE (SPECIFY) M.D. Dep		DATE SIGNED Jan 9 1979					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 12 1979		23c. NAME OF CEMETERY OR CREMATORY Cheltenham Maryland Veterans Cemetery Cheltenham		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Maryland					
24. FUNERAL DIRECTOR NAME Tekon Funeral Home ADDRESS J.A. Waters, 251 Carroll/DENWOOD				25a. DATE REC'D. BY REGISTRAR JAN 18 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy					

73-01888

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY
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WASHINGTON, D. C.

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WASHINGTON, D. C.

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		79-01967		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
George B DAVIS						1 9 79				9:00 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		July 9, 1923		55 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Montgomery County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital				Architect					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. CITY OR TOWN			13b. INSIDE CITY LIMITS?			13c. STREET ADDRESS		
Maryland			Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			222 St Paul St		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
George B Davis				Eliza Juliard							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
No			193-12-8711		Mrs Sarah Thumser		6601 Walther Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4919 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Heart Failure</u> (c) <u>Chronic Bronchitis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			CITY OR TOWN COUNTY STATE		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET					
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 7</u> 19 <u>78</u> , to <u>Jan 9</u> 19 <u>79</u> , that (I) (we) lost the deceased alive on <u>Jan 9</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
<u>Bessie Kim</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<u>Jan 9, 1979</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
<u>Bessie K. Kim</u>						<u>Holy Cross Hospital, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN COUNTY STATE		
Burial			1/12/79		Parkwood		Baltimore, Maryland				
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME Leonard J Ruck Inc Baltimore, Maryland						ADDRESS		JAN 10 1979 <u>Hofny/Adams</u>			

10-01001



released by Dr. Bae & Dr. Bialek
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 50M 7/77
(VRA 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01968 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) William Francis de DuFour				2a. DATE OF DEATH MONTH DAY YEAR 1-30-79		2b. HOUR 12 ⁰⁵ am	
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 11 1925		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physicist		12b. KIND OF BUSINESS OR INDUSTRY Mitre Corp.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM F. deDUFOUR				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LORETTA D. BERGER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 119-20-2544		17. INFORMANT ADDRESS CAROL deDUFOUR (SAME AS 13c)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 4149 } DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Heart Disease } DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH undetermined undetermined							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypertension							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 15, 1973, to 30 Jan 1979, that (I) (we) lost saw the deceased alive on Jan 26, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stanley M Bialek MD.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 30 Jan 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY M. BIALEK				22e. ADDRESS 8218 WISCONSIN AVE., BETHESDA, MD. 20014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-31-79		23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HYDES BALTO. MD.	
24. FUNERAL DIRECTOR NAME ADDRESS ROBERT A. PUMPHREY FUNERAL HOMES P/A ROCKVILLE MD.				25a. DATE REC'D. BY REGISTRAR FEB 5 1979		25b. REGISTRAR'S SIGNATURE History McCreedy	

10-01888

CRIMINAL RECORDS

COLO. COLLECT



Released by Dr. Mayle to Dr. Stevenson
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01969	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANGUS B. DEVORE						2a. DATE OF DEATH MONTH DAY YEAR 1 21 79		2b. HOUR 133A			
3 SEX M		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 4 18 03		6. AGE (IN YEARS LAST BIRTHDAY) 75		7. IF UNDER 1 YEAR MONTHS DAYS 75		8. IF UNDER 24 HRS. HOURS MIN. 75	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HEATING & VENTILATING ENG.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10706 DOUGLAS AVE	
14. FATHER'S NAME JOSEPH CLAYTON DEVORE				15. MOTHER'S MAIDEN NAME CLARABELLE MAGINNIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WW 1 577-03-3965		17. INFORMANT SON		ADDRESS ADELPHI, MARYLAND PAUL A. DEVORE, 9200 EDWARDS WAY			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ACUTE EXTENSIVE MYOCARDIAL INFARCT 410 - DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1) DIABETES MELLITUS 2) ABDOMINAL AORTIC ANEURYSM.											
19a. DATE OF OPERATION 1/20/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED TEMPORARY PAPER FOR HEART BLOCK				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11125 ROCKVILLE PIKE ROCKVILLE, MD							
22a. I certify that (N) (this hospital) attended the deceased from 1/20 19 79 , to 1/21 19 79 , that (I) (we) last saw the deceased alive on 1/20 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I we did not view the body after death)											
22b. SIGNATURE Roger Stevenson MD				DEGREE MD				22c. DATE SIGNED 1/21/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROGER STEVENSON, MD				22e. ADDRESS 11125 ROCKVILLE PIKE ROCKVILLE, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/24/79		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25a. DATE REC'D. BY REGISTRAR JAN 22 1979		25b. REGISTRAR'S SIGNATURE Robert M. Brady			

20-01000

YES AM I 277-00-2962 DANIEL A. DRYGOTZ 2001 ENHANCED AM
JESSE CLAYTON ROGGE DANIELLE
HEATING & PLUMBING, INC.

BRITAIN

1/10/79

DATE OF HEAVEN

SILVER SPRING

MOBILE

500 UNIVERSITY L.L. SILVER SPRING MD. 20901
FRANKS J. COLLINS

JAN 2 1979

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25m. 1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

79-01970

1. DECEASED-NAME (Type or print)		First Benjamin A.P.		Last Doeherer		2a. DATE OF DEATH Month 1 Day 18 Year 79			2b. HOUR 19 M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 13, 1908			6. AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH S.S.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fairland N. Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Accountant C.&P.			12b. KIND OF BUSINESS OR INDUSTRY Telephone			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3367 S. Leisure World Blvd			
14. FATHER'S NAME First Carl Doeherer Middle Last				15. MOTHER'S MAIDEN NAME First Anna Pine Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 577 01 0939		17. INFORMANT Address Emilie Doeherer Wife same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> <u>3368</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>SPINO CEREBELLAR DEGENERATION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cerebral cortical atrophy</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>15 years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic Bronchitis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) UNDERLYING <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from <u>1-13</u> , 19 <u>79</u> , that (I) (we) saw the deceased alive on <u>1-13</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Japon Deiger, M.D.</u>		22c. DATE SIGNED 1-18-79		22d. PHYSICIAN'S NAME (Type) JAPON DEIGER, M.D.							
22e. ADDRESS 8830 CAMERON STREET SILVER SPRING, MD. 20906											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/22/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) Suitland		(County) PG (State) Md.			
24. FUNERAL DIRECTOR Hines/Rinaldi F.H. 11800 N.H. Ave. Silver Spring, Md.				25a. REC'D BY REGISTRAR JAN 22 1979		25b. REGISTRAR'S SIGNATURE <u>Mark McInerney</u>					

79-01970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-01971			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) William J. DOLAN				2b. HOUR 2:05A _M			
3 SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 17 1927		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Army		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Illinois				13b. COUNTY Thornton		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Doan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. Korea, Viet 341 20 4056		17. INFORMANT ADDRESS IL 60438	
18. CAUSE OF DEATH Enter only one number line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC Arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				DUE TO, OR AS A CONSEQUENCE OF (b) Septic			
				DUE TO, OR AS A CONSEQUENCE OF (c) Ascites + Squamous cell ca			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (✓) (this hospital) attended the deceased from Dec. 14, 1978, to Jan. 30, 1979, that I (we) last saw the deceased alive on Jan. 30, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not have a view of the body after death.)							
22b. SIGNATURE [Signature]				DEGREE DO ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Jan. 31, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID J. FONTAINE DO				22e. ADDRESS National Naval Medical Center, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb 2, 1979		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.	
24. FUNERAL DIRECTOR NAME Marshall Funeral Home				ADDRESS Washington, D.C.		25. DATE REC'D. BY REGISTRAR FEB 5 1979	
						25b. REGISTRAR'S SIGNATURE [Signature]	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01972 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carl Shannon Donaldson						2a. DATE OF DEATH MONTH DAY YEAR January 13, 1979		2b. HOUR 1:42 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 27, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. UNDER 1 YEAR MONTHS DAYS 62		7. UNDER 24 HRS. HOURS MIN. 42	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONTRACT OFFICER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND						13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 12709 VALLEYWOOD DRIVE											
14. FATHER'S NAME FIRST MIDDLE LAST E. GUY DONALDSON						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES MARY JACOBSEN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-05-1416		17. INFORMANT NANCY S. DONALDSON				17. ADDRESS SAME AS 13 WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia and heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic emphysema DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive pulmonary disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 wks. Several yrs. Several years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 12-24-78 , 19 78 , to 13-1- , 19 79 , that (I) (we) lost saw the deceased alive on 13-1- , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, that (we) did not view the body after death.											
22b. SIGNATURE Donald E. Dillon				DEGREE MD				22c. DATE SIGNED 14 Jan 79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon, M.D.				22e. ADDRESS 18111 Pr. Philip Dr Olney, Md 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/16/79		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PRI GEO MD.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR JAN 16 1979				25b. REGISTRAR'S SIGNATURE Frederick Kennedy			
500 UNIV. BLVD., W. SILVER SPRING, MD. 20901											

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01973			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Bill W Dowding				2a. DATE OF DEATH MONTH DAY YEAR 1-26-1979 2b. HOUR 11:45 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 17 10		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY FUNERAL	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Prince George 13c. CITY OR TOWN Andrews AFB.				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4241-D Oxon Hill Ct.	
14. FATHER'S NAME FIRST MIDDLE LAST Co Dowding				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Bradley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 270-82-8574		17. INFORMANT ADDRESS JAMES DOWDING (SAME AS 413)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 METASTATIC CARCINOMA OF (R) LUNG DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 30 YRS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE James G. Brown DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/27/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. BROWN, MD				22e. ADDRESS 6525 Belcrest Rd Hyattsville MD 20782			
23a. BURIAL, CREMATION, REMOVAL REMOVAL		23b. DATE 1-30-79		23c. NAME OF CEMETERY OR CREMATORY GEORGETOWN MEMORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON D.C.	
24. FUNERAL DIRECTOR NAME W W CHAMBERS CO. ADDRESS SILVER SPRING MD.				25. DATE REC'D. BY REGISTRAR FEB 5 1979		25b. REGISTRAR'S SIGNATURE Robert McCreedy	

1102 BP

70-010123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01974 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Judy Norena DOWNER						2a. DATE OF DEATH MONTH DAY YEAR January 23 1979			2b. HOUR 3:15A M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 5 1960		6. AGE (IN YEARS LAST BIRTHDAY) 19 YRS MONTHS DAYS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Newfoundland		7b. CITIZEN OF WHAT COUNTRY? CANADA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beautician			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Newfoundland						13b. COUNTY Norris Arm		13c. CITY OR TOWN Norris Arm		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Bromwell Downer						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Piercy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. See Item 13		17. INFORMANT ADDRESS Mrs. Blanche Downer					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute lymphocytic leukemia 2040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from Jan. 22 , 19 79 , to Jan. 23 , 19 79 , that (1) (we) last saw the deceased alive on Jan. 23 , 19 79 , and that injury (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Stephen Bohan</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED Jan. 23 1979		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Stephen Bohan, M.D.						22e. ADDRESS National Naval Medical Center, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-26-79		23c. NAME OF CEMETERY OR CREMATORY Family Plot			23d. LOCATION CITY OR TOWN COUNTY STATE Gander, Newfoundland, Canada		
24. FUNERAL DIRECTOR NAME ADDRESS Metropolitan Funeral Service Alexandria, Va.						25a. DATE RECEIVED BY REGISTRAR Jan 31 1979			25b. REGISTRAR'S SIGNATURE <i>John A. Brady</i>		

BP

79-01974

Study	Therapy	POWER	January 23 1979	2415A
Female	Caesarian	Jan. 2 1960	19	
Newfoundland	CANADA	Laboratory		
Technique	National Naval Medical Center	Beautician		
Newfoundland	Marine	Box 5		
Travis	Conner	Blanche	Piercy	
He		Mr. Blanche Conner - See item 12		

Acute lymphocytic leukemia

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Jan. 23 79
Jan. 23 1979
National Naval Medical Center, Bethesda, Md.
J. Stephen Conner, M.D.
and wife

Autopsion Funeral Service Alexandria, Va.

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-01975
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NICK - DRACOS			2a. DATE OF DEATH MONTH DAY YEAR 1-31-79			2b. HOUR 11 ⁰⁰ AM	
3. SEX MALE	4. RACE GREEK	5. DATE OF BIRTH MONTH DAY YEAR 4-?-1978	6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GREECE	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center		12a. USUAL OCCUPATION (IF NOT WORK FOR MOST OF WORKING LIFE) Restaurant		12b. KIND OF BUSINESS OR INDUSTRY Owner (Retired)		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN Silver Spring		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1400 Fenwick Street				
14. FATHER'S NAME FIRST MIDDLE LAST James			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 578-48-3501 A	17. INFORMANT ADDRESS Angela Dracos Wife (13e)
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Circulatory collapse</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Chronic lymphocytic leukemia, Splenial effusion of uncertain etid.</u>			
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19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
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22a. I certify that (I) (this hospital) attended the deceased from <u>August</u> 19 <u>78</u> , to <u>1/31</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Saturday 1/27</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
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22b. SIGNATURE <u>Herbert S. B. Baraf, MD</u>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1/31/79
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) HERBERT S. B. BARAF, MD	22e. ADDRESS 8750 Georgia Avenue, Silver Spring Md.
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb 3-1979	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont Co. Md.
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24. FUNERAL DIRECTOR <u>Arthur Walters</u>	25. DATE RECD. BY REGISTRAR Feb 6 1979	25b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01976 REG. NO.	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH		2b. HOUR
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Helen L. Lynch Duchesne</i>			MONTH DAY YEAR <i>Jan 30 1979</i>		3 ⁰⁰ A M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR <i>JUNE 7, 1896</i>	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTY) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colonial Villa NURSING HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE OF USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS JOSEPH LYNCH			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST WINIFRED MARY STUTHERS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-74-6743	17. INFORMANT ADDRESS MARY D. DELANY, 803 DOWNS DRIVE		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 4340 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-6 d.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>29 Jan 79</i> to <i>30 Jan 79</i> , that (I) (we) last saw the deceased alive on <i>29 Jan 79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>William D. Aud</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/30/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM D. AUD		22e. ADDRESS 9006 COLESVILLE ROAD, SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 2/2/79	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR FEB 5 1979		25b. REGISTRAR'S SIGNATURE <i>Robert M. Brady</i>	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					

29-01976

TABLE

NAME	DATE	PLACE	REMARKS
THOMAS	1944-1945	U.S.A.	WENT TO WORK
JOSEPH	1944-1945	U.S.A.	WENT TO WORK
FRANK	1944-1945	U.S.A.	WENT TO WORK
MARY E. DELANEY	1944-1945	U.S.A.	WENT TO WORK
DAUGHTER	1944-1945	U.S.A.	WENT TO WORK
SILVER SPRING	1944-1945	U.S.A.	WENT TO WORK
2210 GREEN AVENUE	1944-1945	U.S.A.	WENT TO WORK
WENTON	1944-1945	U.S.A.	WENT TO WORK
X	1944-1945	U.S.A.	WENT TO WORK
WENTON	1944-1945	U.S.A.	WENT TO WORK
WENTON	1944-1945	U.S.A.	WENT TO WORK

TABLE

NAME	DATE	PLACE	REMARKS
FRANK J. COLLINS	1944-1945	U.S.A.	WENT TO WORK
SILVER SPRING	1944-1945	U.S.A.	WENT TO WORK
2210 GREEN AVENUE	1944-1945	U.S.A.	WENT TO WORK
WENTON	1944-1945	U.S.A.	WENT TO WORK
WENTON	1944-1945	U.S.A.	WENT TO WORK
WENTON	1944-1945	U.S.A.	WENT TO WORK

Cleared with Med. Examiner (Dr. Rogers)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		79-01977 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dr. Edward Dunner					2a. DATE OF DEATH MONTH DAY YEAR Jan. 24 1979			2b. HOUR 1015A M.	
3. SEX Male		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR Oct. 4, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Doctor		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Mont.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 12906 Bluhill Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Max Dunner					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fanny Darwin				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 2		17. INFORMANT ADDRESS Reichel Dunner (Same as No. 13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>arteriosclerotic C.V. Disease</u> (c) <u>19 yrs.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1-23</u> , 19 <u>60</u> , to <u>1-23</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>1-23</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bernard H. Ostrow				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-24-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD H. OSTROW				22e. ADDRESS 5225 Pooks Hill Rd BETH. MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/26/1979		23c. NAME OF CEMETERY OR CREMATORY West Pittston		23d. LOCATION CITY OR TOWN COUNTY STATE West Pittston, Luzerne, Pa.			
24. FUNERAL DIRECTOR Donald M. Stein Hebrew Memorial Funeral Home 232 Carroll Street, N. W., Washington, D. C.						25a. DATE REC'D. BY REGISTRAR JAN 29 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

72-0127

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01978	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
FIRST MIDDLE LAST Delorus Mae DUSIK					MONTH DAY YEAR January 11 1979					9:25A M	
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
Female		Caucasian		MONTH DAY YEAR June 10 1912			66 YRS		IF UNDER 24 HRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Virginia		USA					Montgomery MD.				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
Bethesda			National Naval Medical Center				Housewife			Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d INSIDE CITY LIMITS?			13e STREET ADDRESS			
13a STATE 13b COUNTY Virginia N/A					13c CITY OR TOWN Portsmouth YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			237 Plover Drive			
14 FATHER'S NAME FIRST MIDDLE LAST Baillard Preston French					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ollie R. Hughes						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS				
No					223-20-6946		Mrs. Goldie Miller 3500 Henrico St. Norfolk Va. 23513				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacterial endocarditis, status post mitral valve valvulotomy 3949 DUE TO, OR AS A CONSEQUENCE OF (b) Hemorrhagic pneumonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I/this hospital) attended the deceased from Dec. 6, 1978, to Jan. 11, 1979, that (I/ (we) lost above, the deceased alive, on Jan. 11, 1979, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/ (we) did/ did not view the body after death.											
22b. SIGNATURE James K. O'Donnell M.D.								DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Jan. 11, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James K. O'Donnell, M.D.								22e. ADDRESS National Naval Medical Center, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/15/79		23c. NAME OF CEMETERY OR CREMATORY Green Lawn Memorial			23d. LOCATION CITY OR TOWN COUNTY STATE Portsmouth Va.		
24 FUNERAL DIRECTOR NAME ADDRESS Robt. A. Pumphrey Funeral Home, Bethesda, Md.								25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 18 1979			

BP

78-01978

October 1960
January 11 1978
9:25A

Female
Caucasian
June 10 1912
60

Virginia
USA
XX
Kentucky

Bedford
National Level Medical Center
Housewife

Virginia
Portsmouth
X
227 River Drive

Bedford
Freston
French
Office
F. J. Jones

VA 22512

227-22-22 in Mrs. Goldie Miller 2202 Lenoir St., Bedford

Bacterial endocarditis status post aortic
valve valvulotomy
Hemorrhagic pneumonia

X X

Jan. 11 78
Dec. 6 78
Jan. 11 78

Jan. 11, 1978

James G. O'Connell, M.D.
National Level Medical Center, Bedford, Va.

Bedford
Green Lane Hospital
Portsmouth
Va.

Edith A. Murphy Funeral Home, Bedford, Va.



FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01979
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ethel Warthen Duvall			2a. DATE OF DEATH MONTH Jan. DAY 26 YEAR 1979			2b. HOUR 7:10 A.M.					
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH Aug. DAY 23 YEAR 1891		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.					
10 CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4017 Everett St.			
14. FATHER'S NAME FIRST Alfred MIDDLE C. LAST Warthen						15. MOTHER'S MAIDEN NAME FIRST Rebecca MIDDLE Jane LAST Rabbitt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-32-9932B		17 INFORMANT ADDRESS 4715 Edgefield Rd. Mary Louise Garlock, Bethesda, Md. 20014					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Myocardial Infarction Sept. 1978 IMMEDIATE CAUSE (a) Congestive Heart failure 4148 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/9/79 to 1/26/79 , that (I) (we) last saw the deceased alive on 1/26/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)											
22b. SIGNATURE <i>[Signature]</i>						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/26/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MORRIS PERRY, M.D., P.A. 11602 GEORGIA AVENUE						22e. ADDRESS 11602 Georgia Ave., Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL, OR OTHER DISPOSITION (SPECIFY) Burial				23b. DATE Jan. 27, 1979		23c. NAME OF CEMETERY OR CREMATORY Damascus Meth.		23d. LOCATION CITY OR TOWN Damascus, Montg., Md. COUNTY STATE			
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md.						25a. DATE REC'D. BY REGISTRAR JAN 29 1979 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

78-01378

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 7/77
(VRA 15 (4))

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 21b is marked or item 21c is marked, the medical examiner must be notified at once.

1/4/79/100 Medically cleared Dr. Rodgers / Golding

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01980	
1. DECEASED NAME (TYPE OR PRINT) FLORA L ois EARLE						2a. DATE OF DEATH MONTH DAY YEAR January - 4 - 79		2b. HOUR 9:23 PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 19, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House-wife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 11402 Charlton Drive			
14. FATHER'S NAME FIRST MIDDLE LAST James A. Martin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Pearl Leach							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 450-36-6735A		17. INFORMANT Son Dr. Kenneth Earle		ADDRESS 11402 Charlton Drive Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest - 4340 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral infarction DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Generalized arteriosclerosis - arterial hypertension											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2/3/79 to 1/4/79 , that (I) (we) lost saw the deceased alive on 1/4/79 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Stephen H. Jones MD				DEGREE				22c. DATE SIGNED 1/5/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 809 Viers Mill Rd., Rockville, Md. 20852							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 1-4-79		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS 655 W. Balto. St. Balto., Md.				25a. DATE REC'D. BY REGISTRAR JAN 11 1979			
				25b. REGISTRAR'S SIGNATURE [Signature]							

3208
BP

08210-27

TABLE 2

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6 years.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01981	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Mabel E. Echols				2a. DATE OF DEATH MONTH DAY YEAR Jan. 26 1979		2b. HOUR 2:35 P.			
3. SEX F		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 17 1901		6. AGE (IN YEARS LAST BIRTHDAY) 77		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Sil. Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT NURSING FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1310 Cresthaven Drive			
14. FATHER'S NAME FIRST MIDDLE LAST Frantz Bassett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown) Spain							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS 410- 579-22-3310 -A John S. Echols-husband-(same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 1/22, 1/23, 1/25/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Heart block, shock.				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1. 22 , 19 79 , to 1. 26 , 19 79 , that (I) (we) last saw the deceased alive on 1. 26 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Rajindra K. Sarin				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1. 26. 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAJINDRA K. SARIN				22e. ADDRESS 6201 Greenbelt Rd College Pk Md 20740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 29-79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md.					
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				25a. DATE REC'D. BY REGISTRAR JAN 31 1979				25b. REGISTRAR'S SIGNATURE Monty McCreedy			
24. FUNERAL DIRECTOR 8434 Ga. Ave. S.S. Md.											

18210-22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		79-01982		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH		YEAR		2b. HOUR	
Milton			Joseph Eckert			11/4/79		14, 1979		4:35 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
M		W		MONTH DAY YEAR		73 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington DC		U.S.A.				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Washington D.C.		Horton Manor Care Unit				Printing					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Washington D.C.				DC		DC		YES <input type="checkbox"/> NO <input type="checkbox"/>		3109 38th St. N.W.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST			FIRST MIDDLE LAST								
John A. Eckert			Catherine Heitzhaus								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1925-1926			578 0321			Washington DC		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4409 Conditions, if any, which gave rise to immediate cause (b) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u> underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>12 OCT</u> , 19 <u>78</u> , to <u>15 JAN</u> , 19 <u>79</u> , that (I) (the hospital) saw the deceased alive on <u>12 JAN</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			22b. SIGNATURE <u>Waiter E. Goetz</u>			22c. DATE SIGNED <u>15 JAN 79</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
WAITER E GOETZ			2309 Shore Field Road								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			Jan 18 1979		St. Marys Cemetery		Washington D.C.				
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
DeVol Funeral Home			2222 Wisconsin Ave. N.W.			JAN 18 1979			<u>Robert A. DeVol</u>		

BP _____

58010-01

Washington, D.C.

January 1950

Washington, D.C.

Washington, D.C.

Level: General

NAME: Lester Eichner

DATE OF DEATH: January 5, 1979

PLACE OF DEATH: Montgomery County

SEE: #79-04648
February, 1979
Montgomery County

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-01983 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>Philip Emed</u>										2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <u>Jan 11 1979</u>										7b. HOUR <u>10</u> M <u>10</u>			
3. SEX <u>M</u>		4. RACE <u>W</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Oct 12 1929</u>		6. AGE (IN YEARS) (LAST BIRTHDAY) <u>49</u> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD <u>Jan 11 1979</u>										7d. HOUR <u>10</u> M <u>10</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>LEBANON</u>				7b. CITIZEN OF WHAT COUNTRY? <u>LEBANON</u>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery MD</u>											
10. CITY OR TOWN OF DEATH <u>SILVER SPRING</u>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HOLY CROSS HOSP.</u>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>PHYSICIAN</u>				12b. KIND OF BUSINESS OR INDUSTRY <u>MEDICAL</u>							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE <u>Md</u>				13b. COUNTY <u>Prince Georges</u>				13c. CITY OR TOWN <u>Beltsville</u>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>42948 Beltsville No 4</u>									
14. FATHER'S NAME FIRST MIDDLE LAST <u>KHATTAR - EMAD</u>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>KHOULA - KFOURI</u>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>NO</u> (IF YES, GIVE WAR OR DATES) <u>-</u>										16b. SOCIAL SECURITY NO. <u>214-90-7684</u>				17. INFORMANT ADDRESS <u>4520 ELMWOOD RD. BELTSVILLE, MD.</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> <u>4291</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 yr</u>																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Fracture Rt Hip</u>																							
19a. DATE OF OPERATION <u>1-9-79</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Fracture Rt. Hip</u>										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>12 PM 14 1979</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Fell at home</u>															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Home</u>				21f. LOCATION CITY OR TOWN <u>Beltsville</u> COUNTY <u>Prince Georges</u> STATE <u>Md</u>															
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>John S. Rogers</u>				TITLE (SPECIFY) <u>Dep</u>				MEDICAL EXAMINER				DATE SIGNED <u>Jan 14 1979</u>											
EXAMINER'S NAME (TYPE OR PRINT) <u>JOHN S. ROGERS</u>				ADDRESS <u>1919 SEMINARY RD. SILVER SPRING MD</u>																			
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>				23b. DATE <u>1-13-79</u>				23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>				23d. LOCATION CITY OR TOWN <u>SILVER SPRG</u> COUNTY <u>MONT.</u> STATE <u>MD.</u>											
24. FUNERAL DIRECTOR NAME <u>W.W. CHAMBERS</u> ADDRESS <u>SILVER SPRG, Md.</u>																							
25a. DATE RECD. BY REGISTRAR <u>JAN 16 1979</u>										25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>													

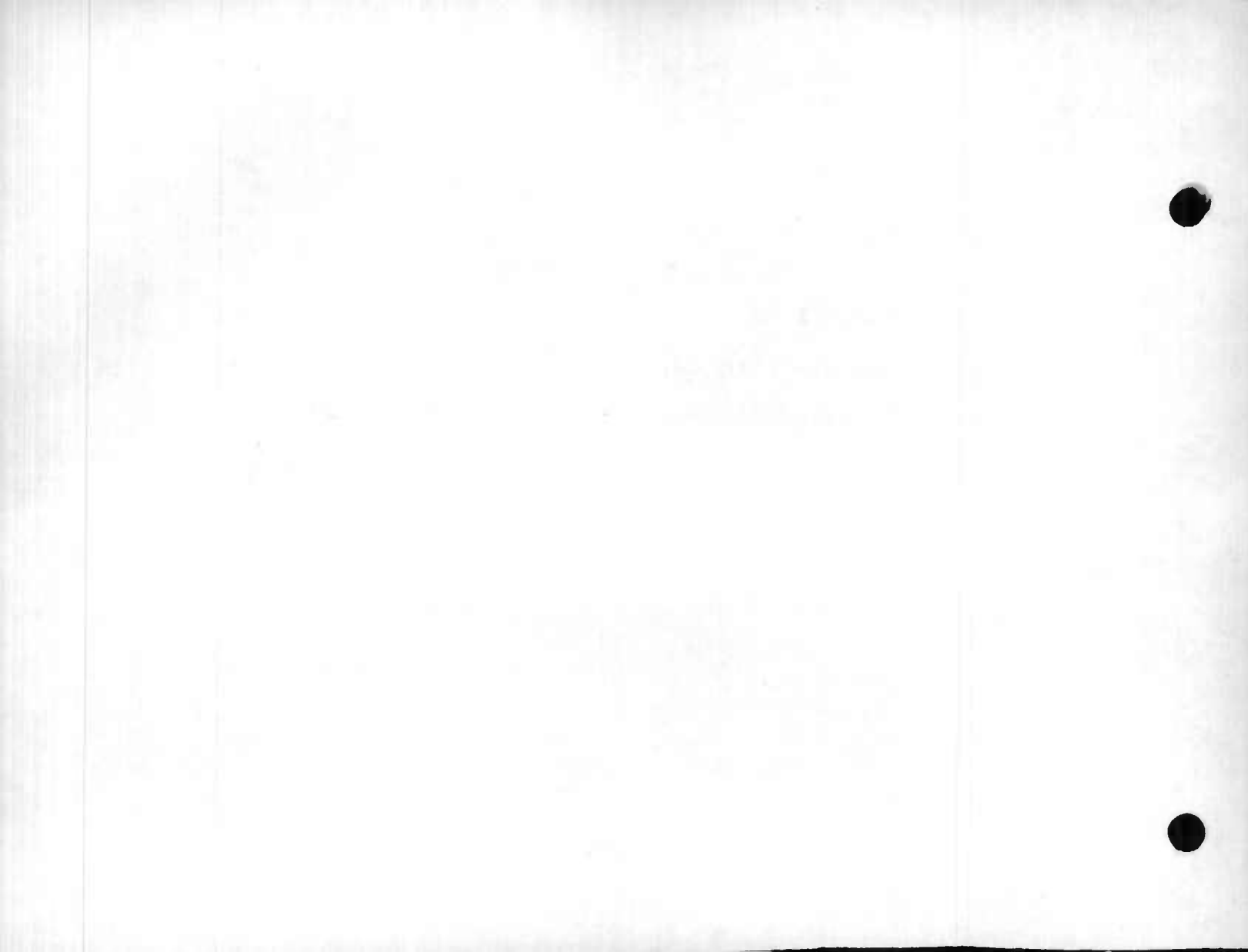
10-01083

NAME: Oscar Noel Ethier

DATE OF DEATH: January 26, 1979

PLACE OF DEATH: Montgomery County

SEE: #79-04653
February, 1979
Montgomery County



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-01984
REG. NO.1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Manice (Name) Evanson			2a DATE OF DEATH MONTH 1 DAY 5 YEAR 79			2b HOUR 9:30 AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH 1 DAY 3 YEAR 38		6 AGE (IN YEARS (LAST BIRTHDAY)) 91 YRS		7 UNDER 1 YEAR MONTHS 1 DAYS 15	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Montgomery, Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3211 HEWITT AVENUE				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Md.				13b COUNTY Montgomery		13c CITY OR TOWN Wheaton		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST Not known MIDDLE Not known LAST Howe				15 MOTHER'S MAIDEN NAME FIRST Not known MIDDLE Not known LAST Not known				13e STREET ADDRESS 3211 Hewitt Ave, Apt 203	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 577-84-1369		17 INFORMANT Sylvia Sheplee (daughter)				ADDRESS same address	
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer breast 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) thrombotic embolism - cardiovascular, antithrombin over 1 yr (c) Advanced age (age 91). Anemia, occult malignancy probable 6 months									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hx multiple TIA, parietal probably 2° occult malignancy									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/22/75 , 19 75 , to 1/5 , 19 79 , that (I) (we) lost saw the deceased alive on 10/11/78 , 19 78 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Michael V. Edelstein MD						DEGREE MD		22c. DATE SIGNED 1/5/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael V. Edelstein MD						22e. ADDRESS WASHINGTON ARLENTISH HOSP. JAYHAWK PARK, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8 Jan 79		23c. NAME OF CEMETERY OR CREMATORY Port Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis Montgomery Md.		
24. FUNERAL DIRECTOR NAME Arthur Walters ADDRESS 254 Carroll St N.W. Washington D.C. 20037						25a. DATE REC'D. BY REGISTRAR JAN 10 1979		25b. REGISTRAR'S SIGNATURE Harvey McQuay	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

18010-25

18010-25

[Faint, illegible handwritten text on lined paper]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-01985	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)					3. SEX					4. RACE	
Edna M. Everhart					Female		Caucasian				
5. DATE OF BIRTH					6. AGE (IN YEARS LAST BIRTHDAY)					7. IF UNDER 1 YEAR	
Oct. 24, 1904					74		MONTHS		DAYS		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					9. BALTIMORE CITY OR COUNTY OF DEATH					10. IF UNDER 24 HRS.	
Virginia					Montgomery					HOURS	
11. CITY OR TOWN OF DEATH					12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					13. KIND OF BUSINESS OR INDUSTRY	
Bethesda					Homemaker					Home	
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					15. INSIDE CITY LIMITS?					16. STREET ADDRESS	
Maryland Montgomery Bethesda					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					8712 Lowell Street	
17. FATHER'S NAME					18. MOTHER'S MAIDEN NAME					19. ADDRESS	
Flavius Lodge					Ella Mae					Not available	
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					21. SOCIAL SECURITY NO.					22. INFORMANT	
No					577 84 3987					Peggy Martin same as item 13	
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410- Coronary Occlusion										4 hr	
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease										15 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
24. DATE OF OPERATION				25. CONDITION FOR WHICH OPERATION WAS PERFORMED				26. AUTOPSY?		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
28. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				29. TIME OF INJURY				30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
31. INJURY OCCURRED				32. PLACE OF INJURY				33. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE			
34. I certify that (I) (this hospital) attended the deceased from 8-29-77 to 1-22-79, that (I) (we) last saw the deceased alive on 1-15-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
35. SIGNATURE				36. DEGREE				37. DATE SIGNED			
Stephen W. Deiter, M.D.								1-23-79			
38. PHYSICIAN'S NAME (TYPE OR PRINT)				39. ADDRESS							
Stephen W. Deiter, M.D.				6719 Wilson La. Bethesda, Maryland							
40. BURIAL, CREMATION, REMOVAL (SPECIFY)				41. DATE				42. NAME OF CEMETERY OR CREMATORY			
Cremation				1/22/79				Metropolitan Crematory Alexandria, Virginia			
43. FUNERAL DIRECTOR NAME				44. DATE REC'D. BY REGISTRAR				45. REGISTRAR'S SIGNATURE			
ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND				JAN 26 1979				Linking McCready			

79-01982

January 22, 1979

Every day

Line

Oct. 24, 1978

Georgian

Female

U.S.A.

Female

Suburban Hospital

Female

Georgian

Female

Male

Male

277-81-2-25 Every day in the morning

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01986	
FOR 1 - REGISTER		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie Louise Fabrizio						2a. DATE OF DEATH MONTH DAY YEAR January 30, 1979			2b. HOUR 4:30 A.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 22, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D. C.						13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST SPENCER DEAN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BEATRICE HALL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT ADDRESS 477 101 3 578-62-1999 DR. RICHARD F. FABRIZIO SAME AS ITEM 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Melanoma 1729 DUE TO, OR AS A CONSEQUENCE OF: (b) Metastatic to lungs, vertebra, and Brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (X) this hospital attended the deceased from 22 January 19 79, to 30 January 19 79, that X (we) last saw the deceased alive on 30 January 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edward C. Bradley		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/30/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. BRADLEY				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/2/79		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON D.C.					
24. FUNERAL DIRECTOR NAME G.P. KALAS 6160 Oxon Hill Rd. Oxon Hill, Md.						25a. DATE REC'D. BY REGISTRAR FEB 1 1979		25b. REGISTRAR'S SIGNATURE Anthony McCready			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01987
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) RAYMOND G. FANNING			2a DATE OF DEATH MONTH DAY YEAR 1 30 79			2b HOUR 8:55 M					
3 SEX M.		4 RACE CAUC		5 DATE OF BIRTH MONTH DAY YEAR 2 16 23		6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS		7 UNDER 1 YEAR MONTHS DAYS		7b UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10 CITY OR TOWN OF DEATH SILVER SPRING		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRIEST		12b KIND OF BUSINESS OR INDUSTRY -			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND 13b COUNTY CHARLES 13c CITY OR TOWN WARDORF											
14 FATHER'S NAME FIRST MIDDLE LAST MICHAEL JAMES FANNING				15 MOTHER'S MAIDEN NAME FIRST MIDDLE MARY J. McDERMOTT							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-20-8192				17 INFORMANT BROTHER ADDRESS KENSINGTON, MD. JEROME W. FANNING, 2908 PEREGOY DRIVE			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY FAILURE 3352 DUE TO, OR AS A CONSEQUENCE OF (b) AMYOTROPHIC LATERAL SCLEROSIS 10 MO. DUE TO, OR AS A CONSEQUENCE OF (c) - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) NONE											
19a DATE OF OPERATION -		19b CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) -							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from AUG 18 19 78 to JAN 30 19 79, that (I) (we) lost saw the deceased alive on JAN 30 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Francis Maylee MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 1/30/79			
22d PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS MAYLEE						22e ADDRESS 8200 WISCONSIN AVENUE, BETHESDA, MARYLAND					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 2/3/79		23c NAME OF CEMETERY OR CREMATORY MT. OLIVET		23d LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.					
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25a DATE REC'D. BY REGISTRAR FEB 5 1979		25b REGISTRAR'S SIGNATURE P. J. Collins			

BP

58010-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		79-0150- 79-01988									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR 330 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 4, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH S.S.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Grocery		12b. KIND OF BUSINESS OR INDUSTRY Self-Empl.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 15801 N.H.Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Marcellus Farrar						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia H. Baber					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 577 48 3097		17. INFORMANT ADDRESS Erma E. Farrar (Wife) Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN METASTASIS DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (c) 1629 Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 6 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/79, 19 79, to 1/29, 19 79, that (I) (we) last saw the deceased alive on 1/26, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE MD KIRKLAND O. BEACE						DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/28/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KIRKLAND O. BEACE						22e. ADDRESS 1600 CARROLL AVE, TAKOMA PARK, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/31/79		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Burtonsville Mont. Md.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.11800						ADDRESS N.H.Ave.S.S.Md.		25a. DATE REC'D. BY REGISTRAR FEB 1 1979		25b. REGISTRAR'S SIGNATURE History McCreedy	

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Male	White	Nov. 4, 1901	77
Virginia	USA	Montgomery	
S.S.	Washington Adventist Hospital Grocery	Self-Emp.	
MA.	Mont.	S.S.	Y
		15801 N.W. Ave.	
Marceline Farrar	Julia H. Farrar		
No	377 AS 3003	Edna E. Farrar (Wife)	Same as above

Burial	1/31/79	Union Cemetery	Burtonsville Mont.
Edna/Rinaldi	15801 N.W. Ave.	S.S.	Y

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMMH-17
(VR A15 ME (5))
15M/77

FOR 1- STATE REGISTRAR												STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 79-01989	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Josephine Marie Feeley						2a. DATE KNOWN OF DEATH ESTIMATED XX MONTH DAY YEAR 1/25 19 79				2b. HOUR 1:40							
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jun. 6, 1894		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 84		IF UNDER 1 YR. MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1/25 19 79		7d. HOUR A.M.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD							
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11235 Oak Leaf Drive, #901				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary				12b. KIND OF BUSINESS OR INDUSTRY Legal					
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11235 Oak Leaf Drive, #901							
14. FATHER'S NAME FIRST MIDDLE LAST John J. Feeley						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Carroll											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. XXXXXXXXXX 577-07-2606		17. INFORMANT James W. Quiggle				ADDRESS 888-17th St. N.W. D.C. Wash.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic arteriosclerotic cardiovascular disease</u> Years DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis.</u> Years												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None																	
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) Deputy MEDICAL EXAMINER						DATE SIGNED 1/25/79							
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial-Removal				23b. DATE 1/28/79		23c. NAME OF CEMETERY OR CREMATORY St. Lawrence Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE West Haven, Conn.							
24. FUNERAL DIRECTOR NAME Joseph Gawber's Sons, Inc						25a. DATE REC'D BY REGISTRAR 1/31/79				25b. REGISTRAR'S SIGNATURE <i>Henry McCready</i>							
ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C.																	

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ON, BROOKLYN, N.Y.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-01990
REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Rosalind R. Fegley | | | | January 1, 1979 | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
10/26/1891 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sylvan Manor Health Care Ctr. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Chevy Chase | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3 East Lenox Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Harry Kunemann | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE
Josephine Rintoul | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT ADDRESS
William H. Fegley, 104 Undercliff Ct., Ridgewood, N.J. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). <u>STROKE</u>
<u>436-</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b). <u>ARTERIO-SCLEROTIC CEREBROVASCULAR DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c).
DUE TO, OR AS A CONSEQUENCE OF | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 HOUR</u>
<u>YEARS</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>DEC 19</u> , 19 <u>77</u> , to <u>JAN 1</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>DEC 19</u> , 19 <u>78</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Daniel Rosenblum</u> MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/1/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Daniel Rosenblum, M.D. | | | | 22e. ADDRESS
10400 Connecticut Ave. Kensington, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/4/79 | | 23c. NAME OF CEMETERY OR CREMATORY
George Washington Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Paramus, New Jersey | |
| 24. FUNERAL DIRECTOR
Robert A. Pumphrey Funeral Homes, P.A.
7557 Wisconsin Ave., Bethesda, MD | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Robert A. Pumphrey</u> | |

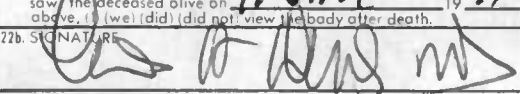

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01991

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JULIA S. FENNEL | | | 2a. DATE OF DEATH
MONTH JANUARY DAY 11 YEAR 1979 | | 2b. HOUR
2:18 P.M. |
| 3 SEX
FEMALE | 4 RACE
WHITE | 5 DATE OF BIRTH
MONTH OCT. DAY 23 YEAR 1916 | | 6 AGE (IN YEARS LAST BIRTHDAY)
62 YRS | IF UNDER 1 YEAR
MONTHS DAYS |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10 CITY OR TOWN OF DEATH
TAKOMA PARK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ARGeo. Co. PUBLIC SCHOOLS | | 12b. KIND OF BUSINESS OR INDUSTRY
CAFETERIA |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a STATE
MD | 13b COUNTY
PR GEO | 13c CITY OR TOWN
TAKOMA PARK | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS
416 CIRCLE AVENUE | |
| 14 FATHER'S NAME
FIRST CLAUDE MIDDLE LAST JERNIGAN | | | 15 MOTHER'S MAIDEN NAME
FIRST LYDIA MIDDLE LAST | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b SOCIAL SECURITY NO.
579-07-3758 | | 17 INFORMANT
JOHN. W. FENNEL | |
| | | | | ADDRESS
416 CIRCLE AVE T.P | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic Insufficiency
1539
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Metastatic Colon Cancer
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 weeks
1 year | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 27 , 19 78 to 11 JAN , 19 79 , that (I) (we) last saw the deceased alive on 11 JAN , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
 | | | | DEGREE
MD | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LEWIS DENNIS, M.D. | | | | 22e. ADDRESS
831 University Blvd F. Sd Spg 40 20903 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 15, 1979 | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN Ortland COUNTY MD STATE MD |
| 24. FUNERAL DIRECTOR
NAME Takoma F.H. Inc. (J.A. Walters) ADDRESS Wash. D.C. 20012 | | | | | |
| 25a. DATE REC'D. BY REGISTRAR
JAN 15 1979 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

10010-07

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-01992 | |
|--|--|---|--|---|---|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) EVA | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 1 16 79 | | | | | 2b. HOUR
12⁵⁰ A.M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR DEC. 25 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
KENSINGTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
KENSINGTON GARDENS NURSING HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MILLINERY | | 12b. KIND OF BUSINESS OR INDUSTRY
LADIES HATS | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN TAKOMA PARK | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7051 CARROLL AVENUE | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST MORRIS FELTMAN | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST IDA LIBBY ELIN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO.
579-09-0647 | | 17. INFORMANT
ADDRESS Mrs. Clara BERNSTEIN 223 GRANT AVENUE TAKOMA PARK, MARYLAND | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory arrest. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate | |
| 410-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF:
(b) Myocardial infarction | | | | | | | | | | 5 minutes | |
| DUE TO, OR AS A CONSEQUENCE OF:
(c) Arteriosclerotic vascular disease | | | | | | | | | | years. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 12/5 19 78 to 1/16 19 79 , that (we) last saw the deceased alive on 12/5 19 78 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
James R. Coleman MD | | | | | | DEGREE | | | 22c. DATE SIGNED
1/16/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES R. COLEMAN | | | | | | 22e. ADDRESS
9241 COLUMBIA BLVD SILVER SPRING, MD. 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | | 23b. DATE
Jan. 18, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
BETH EMETH MEM. PARK WILMINGTON | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
DELAWARE | | | |
| 24. FUNERAL DIRECTOR
NAME Donald M. Stein Hebrew Memorial F.H. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 19 1979 | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |
| 232 Carroll Street, N. W. Washington, D. C. | | | | | | | | | | | |

13-01225

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-01993 | |
|---|--|--|--|---|---|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) Richard W. Fisher | | | | | 2a. DATE OF DEATH
1 Month 18 Day 79 Year | | | 2b. HOUR
12:40 AM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Apr. 8, 1906 | | | 6. AGE (In years lost birthday)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | Md. | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Brooke Grove Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Co-Owner | | | 12b. KIND OF BUSINESS OR INDUSTRY
James A. Messer Co. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
5418 Grove St. | | | |
| 14. FATHER'S NAME
First Martin Middle B. Last Fisher | | | 15. MOTHER'S MAIDEN NAME
First Florence Middle Newburn Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO.
225-05-1846 | | 17. INFORMANT
Daughter, Gail Mentges, 1014 Ashton Rd., Ashton, Md. | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular failure
429.2
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Resistant Hemiplegia & aphasia
DUE TO, OR AS A CONSEQUENCE OF
(c) Cerebrovascular disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days
years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/18/78 , to 1/18/79 , that (I) (we) last saw the deceased alive on 1/16/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
C. H. Ligon | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/18/79 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
C. H. Ligon | | | | | 22e. ADDRESS
1811 P. Phillips Dr., Chevy Chase, Md. 20815 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1/20/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park | | | 23d. LOCATION (City or Town) (County) (State)
Rockville, Maryland. | | | | |
| 24. FUNERAL DIRECTOR
JOSEPH GAWLER'S SONS INC. | | | | | 25a. REC'D BY REGISTRAR
DATE
JAN 22 1979 | | 25b. REGISTRAR'S SIGNATURE
Henry McCreedy | | | | |

10-01003

RECEIVED
FBI
JAN 10 1964



TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum format with various lines of text and possibly a signature block at the bottom.]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01994

REG. NO.

| | | | | | |
|---|--|--|---|--|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | MONTH DAY YEAR | | MONTH DAY MIN | |
| Noralie U. Fitzsimmons | | Jan. 5, 1979 | | 11:40 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| Female | Cauc. | MONTH DAY YEAR | 80 YRS. | MONTHS DAYS HOURS MIN | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Pennsylvania | U.S.A. | | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Bethesda | Bethesda Retirement Nursing Ctr. | | Clerk | | Oil Co. |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| Md. | Montg. | Bethesda | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 304 Parkhill Terr. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| Thomas F. Fitzsimmons | | Annie M. Barry | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 165-05-7248A | | Mary G. Fitzsimmons (Same as 13e) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cerebrovascular disease | | | | | 3-4 months |
| 4370 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral atherosclerosis | | | | | Years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Spontaneous fracture of femur; Chronic pulmonary disease; Atherosclerotic heart disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | 19 | | | |
| 21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-17, 1971, to 1-5, 1979, that (I) (we) last saw the deceased alive on 12-14, 1978, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Joseph A. Romeo M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 1/5/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Joseph A. Romeo M.D. | | 10401 Old Georgetown Rd. Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 1-8-79 | | Gate of Heaven Cem. | |
| 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | |
| Silver Spring | | | | Md. | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Md. | | | | JAN 11 1979 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | L. H. McCreedy | |

79-01994

Witnesses

Notary

Witnesses

Notary

Witnesses

Notary

Witnesses

Notary

Witnesses

Notary

Witnesses

Notary

Witnesses

Notary

Witnesses

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Witnesses

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Witnesses

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Witnesses

Notary

Witnesses

Notary

Witnesses

Notary

Witnesses

Notary

Witnesses

Notary

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01995

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) INFANT Boy Focht | | | 2a. DATE OF DEATH MONTH 1 DAY 26 YEAR 79 | | 2b. HOUR 5:30 M |
| 3 SEX Male | 4 RACE White | 5. DATE OF BIRTH MONTH 1 DAY 26 YEAR 79 | | 6 AGE (IN YEARS LAST BIRTHDAY) - YRS | IF UNDER 1 YEAR MONTHS - DAYS - HOURS 3 MIN 15 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None | | 12b. KIND OF BUSINESS OR INDUSTRY ----- |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Cherry Chase | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 5500 Friendship #1216 | | |
| 14. FATHER'S NAME FIRST Stephen A. MIDDLE H. LAST Focht | | | 15. MOTHER'S MAIDEN NAME FIRST Candee MIDDLE S. LAST Davis | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ADDRESS Cherry Chase, Md.
Stephen A. Focht, 5500 Friendship Blvd | |

MEDICAL CERTIFICATION

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) non-viable 24-25 week gestation fetus
7650
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 1/2 hours |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | |
|--|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/26/79 , 19____, to____, 19____, that (I) (we) lost
saw the deceased alive on____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE R. H. Coleman MD | | 22c. DATE SIGNED 1/26/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. H. COLEMAN MD | | 22e. ADDRESS 11119 ROCKVILLE PIKE, ROCKVILLE | |

| | | | |
|---|--------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | 23b. DATE 1-29-79 | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory | 23d. LOCATION CITY OR TOWN Brentwood COUNTY Maryland STATE |
| 24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels ADDRESS Rockville, Md.
1170 Rockville Pike | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20010-8x

OFFICE OF THE
DIRECTOR
OF THE
BUREAU OF
LANDS

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

79-01996

| | | | | | | | | | | | | |
|---|--|---|---|---|--|---|---|--|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) <u>Grace Lovell Forkel</u> | | | 2a. DATE OF DEATH
Month <u>January</u> Day <u>14</u> Year <u>1979</u> | | | 2b. HOUR
<u>9:15</u> M | | | | | | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
<u>January 17, 1917</u> | | 6. AGE (In years last birthday)
<u>61</u> YRS. | | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | | IF UNDER 24 HRS
HOURS _____ MIN. _____ | | |
| 7a. BIRTHPLACE (State or foreign country)
<u>OHIO</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Montgomery</u> Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>SILVER SPRING</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>9221 WATSON ROAD</u> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>TEACHER</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<u>MARYLAND</u> | | | 13b. COUNTY
<u>MONTGOMERY</u> | | 13c. CITY OR TOWN
<u>SILVER SP.</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<u>9221 WATSON ROAD</u> | | | |
| 14. FATHER'S NAME First Middle Last
<u>WILLIAM O. LOVELL</u> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<u>MARY HAMILTON</u> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | | 16b. SOCIAL SECURITY NO.
<u>578-20-5362</u> | | 17. INFORMANT Address
<u>FREDERICK W. FORKEL SAME AS 13 HUSBAND</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of the breast with metastases</u> <u>Several years</u>
<u>1749</u>
DUE TO, OR AS A CONSEQUENCE OF <u>especially to bone</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____ | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>1974</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Carcinoma of the breast (R)</u> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. _____ Month _____ Day _____ Year _____
P.M. _____ 19 _____ | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work _____ at work _____ | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1972</u> , 19____, to <u>Jan. 14</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>January 14 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Bennet A. Porter Jr.</u> M.D. DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>January 14, 1979</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Bennet A. Porter Jr., M.D.</u> | | | | | | 22e. ADDRESS
<u>9301 Colesville Rd., Silver Spring, Md. 20901</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE
<u>1/17/79</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>FT. LINCOLN</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>BRENTWOOD PRI GEO MD.</u> | | | | | | |
| 24. FUNERAL DIRECTOR
<u>FRANCIS J. COLLINS</u> ADDRESS
<u>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</u> | | | | | | 25a. REC'D BY REGISTRAR
DATE <u>JAN 16 1979</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Jeffrey H. Brady</u> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

00000-0000



1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01997
REG. NO.

| | | | | | | | | | | |
|---|--|---|---|--|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Wilbur Joseph FOURNIER | | | 2a. DATE OF DEATH MONTH DAY YEAR
1-29-79 | | | 2b. HOUR
7 P. M. | | | | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 4 1904 | | 6 AGE (IN YEARS LAST BIRTHDAY)
74 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MASSACHUSETTS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED PRINTER | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOVT. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
GERMANTOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
19048 STALEYBRIDGE RD. | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
PETER FOURNIER | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELIZABETH HAMMOND | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO.
010-05-5202 | | 17 INFORMANT
ADDRESS
DOROTHY E. FOURNIER (SAME AS 13E) | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) pulmonary infection
DUE TO, OR AS A CONSEQUENCE OF
(b) pulmonary infection - pulmonary embolism
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic lymphatic leukemia
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)
liver enlargement - Deep Thrombophlebitis R. leg. | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-14-79 to 1-29-79 , that (I) (we) last saw the deceased alive on 1-29-79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
H. Bahar | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
1-29-79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HADI BAHAR | | | 22e. ADDRESS
8218 Wisconsin Ave Bethesda | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) CREMATION | | | 23b. DATE
1-31-79 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA FAIRFAX VA. | | | |
| 24 FUNERAL DIRECTOR
NAME
ROBERT A. PUMPHREY FUNERAL HOMES P/A | | | ADDRESS
ROCKVILLE MD. | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

78-01337

COLL M. H. D.



FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REC. NO. 79-01998

| | | | | | | | | | |
|---|--|---|---|---|-------------------------------------|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Minnie G. Fox</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1-15-79</i> | | | 2b. HOUR <i>11 10 AM</i> | | | |
| 3 SEX <i>Female</i> | | 4 RACE <i>white</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 28 1895</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <i>Maryland</i> | | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Kensington</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Daniel L. Clark</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret Hardesty</i> | | | 13e. STREET ADDRESS <i>4310 Knoles Avenue,</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>none</i> | | 17. INFORMANT ADDRESS <i>Edna M. Crum-dau- 404 Lanark Way S.S. Md. 20901</i> | | | | | |

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|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Renal failure</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> | |
| 1541
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Recurrent Carcinoma returning & obstr to ureters</i> | | <i>8 months</i> | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Carcinomatosis</i> | | <i>3 months</i> | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/78</i> , 19 <i>78</i> , to <i>1/15</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>1/15</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>J.R. Thistlethwaite</i> | | | | DEGREE <i>ATTENDING PHYSICIAN</i> MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>1/15/79</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J.R. Thistlethwaite, MD</i> | | | | 22e. ADDRESS <i>916 19th Street, S.W. Wash., D.C.</i> | | | |

| | | | | | | | |
|---|--|--------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>1-18-79</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Rockville Union</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville Montgomery Md.</i> | |
|---|--|--------------------------|--|---|--|---|--|

1
4-500
BP
DHMM - 16 50M 7/77 (VR A 15 (4))
FUNERAL DIRECTOR: *Warner E. Pumphrey, Inc.*
18434 Ga. Ave., S.S. Md. *Clark E. Wilson*
25a. DATE REC'D. BY REGISTRAR *JAN 22 1979*
25b. REGISTRAR'S SIGNATURE *Harry McCready*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

80010-07

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-01999

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|---|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ADOLPH L. FRANK | | | 2a. DATE OF DEATH MONTH DAY YEAR
JAN 21 79 | | | 2b. HOUR
5:20 AM | | | | |
| 3 SEX
MALE | | 4 RACE
CAUC. | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 25, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS | | 7. UNDER 1 YEAR
MONTHS DAYS
60 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | |
| 10. CITY OR TOWN OF DEATH
S.S. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bookkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY
Self-Emp. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
S.S. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John C. Franke, Sr. | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lena F. Koepper | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
577 38 3706 | | 17. INFORMANT ADDRESS
Louise Franke (Wife) same as above | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 410 - Acute Myocardial infarct -
DUE TO, OR AS A CONSEQUENCE OF (b) Severe coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF (c) Recurrent cardiac arrhythmia
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
HOURS. 70 MINS. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT. 19 78 , to JAN. 21 19 79 , that (I) (we) last saw the deceased alive on JAN 17 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Albert H. Grollman, MD | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/21/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALBERT H. GROLLMAN, MD | | | 22e. ADDRESS
1106 SPRING ST. SILVER SPRING, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
1/25/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery Suitland | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
PG Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi F.H. | | | ADDRESS
11800 N.H.Ave. Silver | | | 25a. DATE REC'D. BY REGISTRAR
JAN 24 1979 | | 25b. REGISTRAR'S SIGNATURE
Robert M. Brady | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

79-01999

Feb. 22, 1918

Montgomery

USA

Wash. D.C.

Self-Eng.

Bookkeeper

Holy Cross Hospital

S.S.

1802 Hampshire Green Lane

3

S.S.

Home

Ms.

John W. Cooper

John O. Branne, Sr.

777 28 3706 Louise Branne (Wife) same as above

No

1/25/79 Cedar Hill Cemetery Oakland, Ca. Ms.

Serial

Misses/Elizabeth E.H. 11000 N.H. Ave. Silverdale, WA 98158

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 7/77
(VRA 15 (4))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02000 | |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Cecile | | MIDDLE
M | | LAST
French | | 2a. DATE OF DEATH | | MONTH DAY YEAR | |
| 3. SEX
F | | 4. RACE
Cauc. | | 5. DATE OF BIRTH | | MONTH DAY YEAR
11 24 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 81 YRS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY)
Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR
INDUSTRY
own home | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Nursing Home | | 12c. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12d. KIND OF BUSINESS OR
INDUSTRY
own home | | 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | |
| 14. FATHER'S NAME | | FIRST
James | | MIDDLE
E. | | LAST
Maryott | | 15. MOTHER'S MAIDEN NAME | | FIRST
(Unknown) | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
none | | 17. INFORMANT
Richard H. French-son- | | ADDRESS
2503 McComas Ave | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Ca of Uterus
179-
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
6 mo. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/2 19 79 to 1/22 19 79, that (I) (we) lost
saw the deceased alive on 1/2 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE
Myron L. Leukin | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Myron Leukin | | 22e. ADDRESS
2309 Shorefield Rd Wheaton, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Jan 25 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pr. Georges Md | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Warner E. Humphreys | | 24b. ADDRESS
8434 Ga. Ave.,
Sil. Spr. Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 29 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

BP

79-05000

Case No. 79-05000

1979

USA

James Earl Ray
1928-01-05
1979-01-05

(Mugshot)

Ray, James

James

1928-01-05
1979-01-05

1979

1979

1979

James Earl Ray

1928-01-05

1979-01-05

1979-01-05

1979-01-05

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02001

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|------------------------------------|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Rae M Friedlander | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan 1 79 | | | 2b. HOUR
10 ³⁰ A M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
November 27, 1884 | | 6. AGE (IN YEARS LAST BIRTHDAY)
94 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Mont. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales | | 12b. KIND OF BUSINESS OR INDUSTRY
Ladies Clothing | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Maryland | | | 13c. COUNTY
Montgomery | | 13d. CITY OR TOWN
Silver Spring | | 13e. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Herman | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Greene | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
No | | | |
| 17a. SOCIAL SECURITY NO.
578-14-7006 | | | 17. INFORMANT
4701 Willard Ave., #1412
Edward Friedlander Chevy Chase, Md. 20015 | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 5745 VENTRICULAR TACHYCARDIA
DUE TO, OR AS A CONSEQUENCE OF (b) COMMON BILE DUCT OBSTRUCTION ^{DUETO STONE}
DUE TO, OR AS A CONSEQUENCE OF (c) PANCREATITIS + POSS. SEPTIC SHOCK
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MINUTES
4 DAYS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
HYPERTENSIVE CARDIOVASCULAR DISEASE - NONAGENARIAN | | | | | | | | | |
| 19a. DATE OF OPERATION
1-1-79 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
OBSTRUCTIVE JAUNDICE | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/30 1978, to 1-1 1979, that (I) (we) lost saw the deceased alive on 1978, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Ira Miller, MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
1-1-79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
IRA MILLER | | | | 22e. ADDRESS
8218 Wisconsin Ave, Bethesda MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/4/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Memorial Garden | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church, Virginia | | | |
| 24. FUNERAL DIRECTOR
Donald M. Stein Hebrew Memorial F.H.
232 Carroll Street, N. W. Washington, D. C. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 8 1979 | | 25b. REGISTRAR'S SIGNATURE
Rafaela McCurdy | | | |

MEDICAL CERTIFICATION

Closed by R. V. Heller, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or blank, it should be checked by any injury, or other traumatic event, the medical examination must be notified to the State.

10050-02

10050-02

10050-02

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 79-02002
REG. NO. | | | |
|--|--------|--|--|--|--------------|--|--|---|--|---|-----|--|----------|
| 1- STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Elsie | MIDDLE
R. | LAST
Friedmann | | 2a. DATE KNOWN OF DEATH
ESTIMATED | | <input checked="" type="checkbox"/> MONTH | DAY | YEAR | 2b. HOUR |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD | | 1/13 1979 | | 10:30 | |
| Female | White | 11 22 91 | | 87 YRS. | | | | 1/13 1979 | | | | P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | MD | |
| New York | | U. S. A. | | | | Montgomery County | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Bethesda | | 7108 Wilson Lane | | Homemaker | | Home | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| | | | | Maryland | | Montgomery | | Bethesda | | | | 7108 Wilson Lane | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | |
| John | | | | Friedmann | | | | Elizabeth | | | | Hess | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | 4720 Montgomery Lane | |
| No | | | | 215-54-5972 | | | | Clarence C. Keiser, Bethesda, MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u>
4291
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | |
| None | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | | | | | | None | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | |
| | | | | Deputy | | | | 1/14/79 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | |
| John S. Rogers, M.D. | | | | Silver Spring, Montgomery, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | | 1-17-79 | | Greenwood Cemetery | | Brooklyn, New York | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| ROBERT A. PUMPHREY FUNERAL HOMES, P.A., Bethesda, Maryland | | | | JAN 18 1979 | | | | | | | | | |

100-00000

TO DIRECTOR, FBI
FROM SAC, NEW YORK
SUBJECT: [illegible]

NY

11-22-67

NY

U.S.A.

NY

11-22-67

U.S.A.

NY

11-22-67

U.S.A.

NY

NY

11-22-67

U.S.A.

NY

11-22-67

11-22-67

NY

11-22-67

11-22-67

NY

NY

11-22-67

11-22-67

11-22-67

11-22-67

11-22-67

11-22-67

11-22-67

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or after traumatic event, the medical examiner must be notified.

IMPORTANT: If Item 21 is marked or Item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REC'D WITH MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02003 | | | |
|---|--|---|--|---|--|--|--|---|--|--|--|----------|--|
| FOR
STATE
REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Reginald R. E. Gaines | | | | Jan. 28, 1979 | | 579 | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | | | |
| MALE | | WHITE | | Aug. 30 1949 | | 79 | | MONTHS | | DAYS | | HOURS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| VIRGINIA | | U.S.A. | | | | MONTGOMERY | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| SILVER SPRING | | BEL PRE HEALTH CARE CENTER | | SALESMAN | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| MARYLAND | | | | MONTGOMERY | | WHEATON | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3036 BEL PRE ROAD, # 101 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| ROBERT S. GAINES | | | | EVA M. MARKS | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| NO | | | | 224-54-4474 | | EVELYN N. GAINES | | SAME AS 13 | | WIFE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a).
185-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b).
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| CARCINOMATOSIS DIFFUSE
UREMIA
PROSTATE | | | | | | | | | | 6-12 Mo
6-12 Mo
4 YRS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
DIABETES : CONGESTIVE AT FAILURE | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/11/77 to 1/28/79, that (I) (we) lost saw the deceased alive on 1/28/79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | 22b. SIGNATURE
Donal R. Lewis MD | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/29/79 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | |
| D. R. LEWIS MD | | | | OLNEY, Md. 20832 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| BURIAL | | | | 1/31/79 | | COLOMBIA GARDENS | | ARLINGTON VIRGINIA | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| FRANCIS J. COLLINS
500 UNIV. BLVD., W. SILVER SPRING, MD. 20901 | | | | JAN 29 1979 | | [Signature] | | | | | | | |

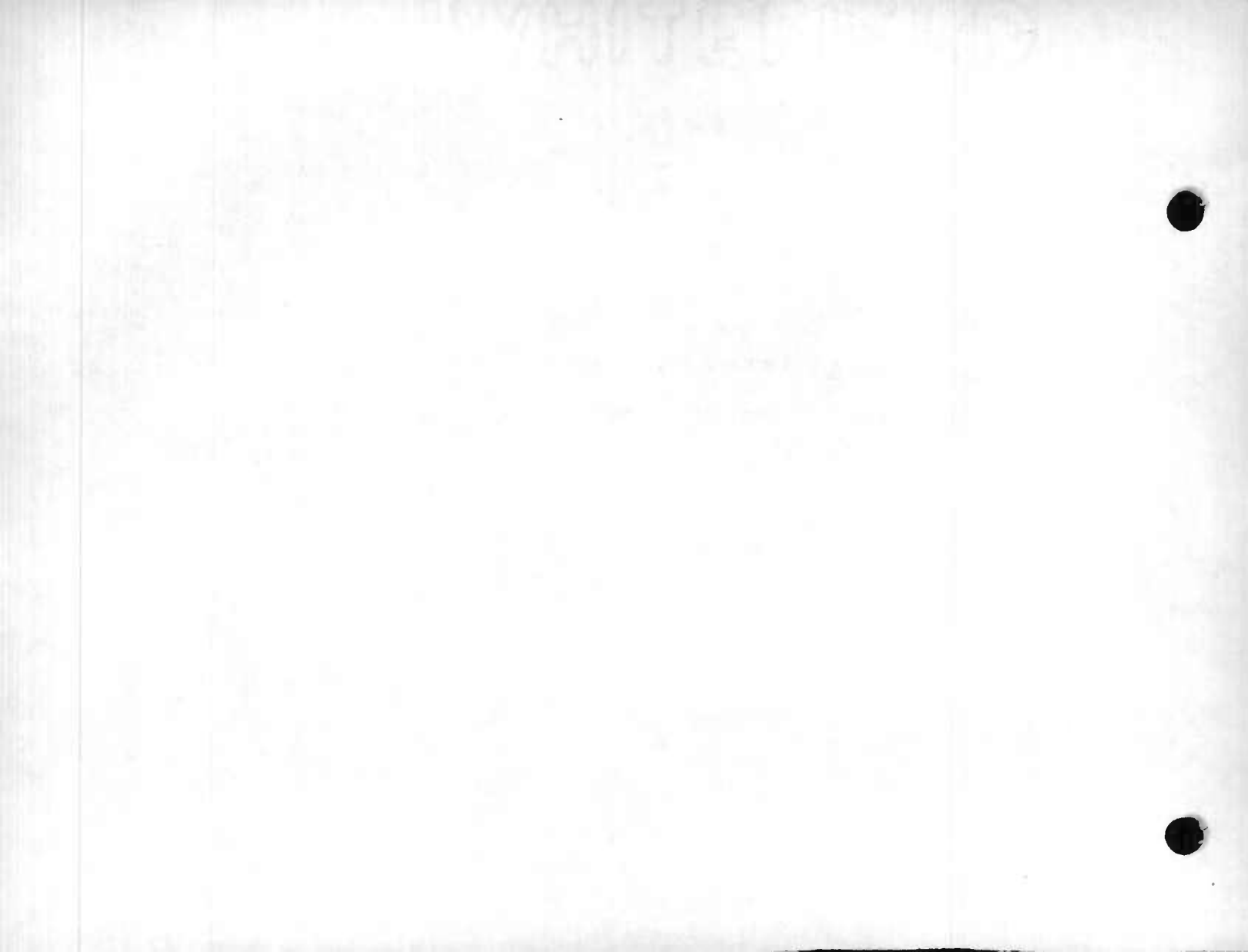
79-02003

NAME: Max Gans

DATE OF DEATH: January 18, 1979

PLACE OF DEATH: Montgomery County

SEE: 79-04661
February, 1979
Montgomery County



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02004

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James A. rvie Garrett Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 19, 1979 | | | 2b. HOUR
12:16P M | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 1, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Tenn. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Professor | | 12b. KIND OF BUSINESS OR INDUSTRY
College Education | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Derwood | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
18704 Rocky Way | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Robert Garrett | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Henrietta - Glosson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWI 430-70-2546 | | 17. INFORMANT
ADDRESS
James A. Garrett, Jr. Same as above | | | | #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma of rectum
1541
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
14 Months | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July , 19 75 , to Jan , 19 79 , that (I) (we) last saw the deceased alive on 1/17 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
A. D. Boleff M.D.
22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. D. BOLEFF M.D. | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/19/79 | | |
| 22e. ADDRESS
18711 Ponce de Leon Dr. Chevy Chase, Md. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal-Burial | | | 23b. DATE
Jan. 22, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Oakland Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Monticello Drew Arkansas | | | |
| 24. FUNERAL DIRECTOR
NAME
Francis H. Barber | | | | | | ADDRESS
Laytonsville, Md. 20760 | | 25a. DATE RECD. BY REG. HQR. JAN 22 1979 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
per [Signature] | | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of occurrence.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 ready to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

12-05004

x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02005
REG. NO.

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Paul Francis Gaughran | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan. 30, 1979 | | 2b. HOUR
12:45A | |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
5 20 15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Massachusetts | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Cty. MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6204 Hollins Drive | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Consultant | | 12b. KIND OF BUSINESS OR INDUSTRY
US Gov't AEC |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland | | 13b. COUNTY Montgomery | 13c. CITY OR TOWN Bethesda | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward Gaughran | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Ellen Foley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WW II | | 16b. SOCIAL SECURITY NO.
015-18-4659 | | 17. INFORMANT ADDRESS
Charlotte Gaughran 6204 Hollins Dr. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the Colon (6-78)
1539
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 Months | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
(OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 18, 79, 19 79, to Jan. 30, 19 79, that (I) (we) last saw the deceased alive on Jan. 18, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
Richard W. Holt | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-30-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard W. Holt, M.D. | | 22e. ADDRESS
3800 Reservoir Rd., N.W. Wash., D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Spring 79 | | 23c. NAME OF CEMETERY OR CREMATORY
Prospect Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Vergennes, Vermont | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | 25a. DATE RECD. BY REGISTRAR
FEB 3 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

10-05002

DATE OF BIRTH

10-05002

10-05002

10-05002

10-05002

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79-02006

NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Kathryn Lewis Gayton | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JAN 29 79 | | 2b. HOUR
5:45 A.M. | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 7 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS
MONTHS DAYS HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Carriage Hill of Silver Spring | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | | |
| 13a. STATE
Md | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Cherry Chase | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3817 Williams Lane | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Lewis | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Charlotta Moore | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
578-03-3315 | | 17. INFORMANT
Daughter ADDRESS
Md. Jane Dean, 223 W. Montgomery Ave., Rockville | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE
4140 DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE, DIABETES | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from about 19 65 , to 1/29 19 79 , that (I) (we) last saw the deceased alive on 1/29 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Richard H. Pollen | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/29/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard Pollen, M.D. | | | | | | 22e. ADDRESS
10400 Conn. Ave., Kensington, Maryland. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
2/1/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, Maryland. | | | |
| 24. FUNERAL DIRECTOR
NAME
JOSEPH CAWLER'S SONS INC.
ADDRESS
5130 WISC. AVE., N. W. WASH., D. C. 20010 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 31 1979 | | 25b. REGISTRAR'S SIGNATURE
Jeffrey McCreedy | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-02007

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Alan E. Gebhardt | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 2 79 | | | 2b. HOUR
12:50 P.M. | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 30 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4302 Marionet St | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Contract Specialist FAA | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles E. Gebhardt | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marian E. MILLER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT
ADDRESS
Marian K. Gebhardt (same as 13e) | | | |

| | | | | | |
|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of brain</u>
1919
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 yrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION
May 1977
May 1978 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma of brain | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-24</u> , 19 <u>78</u> , to <u>1/2</u> , 19 <u>79</u> , that (I) (we) last saw the deceased at <u>12-24</u> , 19 <u>78</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
W. G. Hall | | | | 22c. DATE SIGNED
1/2/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
W.G. HALL | | | | 22e. ADDRESS
615 W. Montgomery Ave., Rockville, Md. | |

| | | | | | | | |
|--|--|---------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1-4-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
ROBERT A. PUMPHREY FUNERAL HOMES P/A MD. ROCKVILLE | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 11 1979 | | 25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey | |

58-05003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02008 | |
|--|--|------------------------------|---|--|------------------------------------|--|--|----------------------------|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| JOSEPH A GERACI | | | Jan, 11, 79 | | | 11:15 AM | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | |
| M | | Can. | | July 25 85 | | 93 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Italy | | U.S.A. | | | | Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Silver Spring | | | 9501 Coleville Rd. S.S. | | | Tailor | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 12c. STATE | | 13. COUNTY | | 13a. CITY OR TOWN | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS | | | |
| MARYLAND | | MONTGOMERY | | SILVER SPRING | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 9501 COLESVILLE ROAD | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | |
| Not known | | | | Not known | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. ADDRESS | | | |
| No | | | | 579-01-5522 | | CLAYMORE P. GERACI | | SON | | | |
| | | | | | | XXXXXX XXXXXX | | 4501 Coleville Rd. S.S. md | | | |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) B Cardiac and resp arrest. | | | | | | | | | | | |
| 436- DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) Stroke and old age | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 19 78 to Jan 11 19 79, that (I) (we) last saw the deceased alive on Jan 3 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | | | | 22c. DATE SIGNED | | |
| [Signature] | | | | | | | | | 1/11/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | |
| SMITH S. Ho | | | 8323 Haddon Dr. Takoma Park, Md 20912 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | |
| BURIAL | | | 1/15/79 | | GEORGE WASHINGTON | | | ADELPHI | | | |
| | | | | | | | | CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | PRT GEO MD. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25. DATE RECD. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| FRANCIS J. COLLINS | | | | | | JAN 12 1979 | | | [Signature] | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD., 20901 | | | | | | | | | | | |

80050-05

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02009
REG. NO.

| | | | | | |
|--|---|---|---|--|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Kasson S. Gibson | | Jan. 5, 1979 | | 11:55P ^M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Male | Caucasian | 1/7/1890 | 88 | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| New York | U.S.A. | | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Rockville | Rockville Nursing Home | | Physicist | | Bureau of Standards |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | Montgomery | Chevy Chase | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 4817 Cumberland Avenue | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
| Stanford J. Gibson, Sr. | | | Gertrude Sage | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 077-32-5717 | | Mildred B. Gibson, same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cerebral Vascular Accident</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Cerebral Arteriosclerosis</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>6 hrs.</u>
<u>10 days</u>
<u>5 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from <u>Jan 1978</u> , 19 <u>1978</u> , to <u>Jan</u> , 19 <u>1979</u> , that (we) lost
saw the deceased alive on <u>Dec 26</u> , 19 <u>78</u> , and that (we) (our) opinion death occurred on the date and hour and from the causes stated
above. (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>John D. Herman M.D.</u> | | | | 22c. DATE SIGNED
1/6/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John D. Herman, M.D. | | | | 22e. ADDRESS
4425 Montgomery Ave., Bethesda, MD | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| Burial | | 1/8/79 | Mt. Hope Cemetery | | Norwich, New York |
| 24. FUNERAL DIRECTOR
Robert A. Pumphrey Funeral Homes, P.A.
7557 Wisconsin Ave., Bethesda, MD | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 11 1979 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Patricia McCreedy</u> | |

The medical examiner must be notified at once.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires, that the death certificate be executed within 24 hours after death. Page 4 of 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12-05009

11:22

Jan. 2, 1979

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John D. Norton, D.D.

Edison

Edison

Edison

TO HOSPITALS, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02010
REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Sophie N. Gigmansovsky | | | 2a. DATE OF DEATH
MONTH DAY YEAR
01 19 79 | | | 2b. HOUR
1:55 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 2 1886 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
Stateless | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | | | | | |
| 13a. STATE
Silver Sprg Montg | | | | 13b. COUNTY
Silver Spg | | 13c. CITY OR TOWN
Silver Spg | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Nichols Troubatcheff | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sophie Berdnikoff | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | 17. INFORMANT
ADDRESS
C.W. Boldyriff, 9208 Columbia Blvd., SS | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardio respiratory failure

4140

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) ASHD with cardiac anky Humias

DUE TO, OR AS A CONSEQUENCE OF (c) and right lung lesion with CHF.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (the hospital) attended the deceased from 1/10 19 79, to 1/19 19 79, that (1) (we) last saw the deceased alive on 1/18 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Joseph M. Solinas MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/19/1979 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joseph M. Solinas., M.D. | | | | 22e. ADDRESS
9801 Georgia Ave, Silver Spring, 20910 | | | |

| | | | | | | | |
|---|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1-22-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | |
| 24. FUNERAL DIRECTOR
NAME
W.W. Chambers.Co | | | | ADDRESS
8655 Georgia Ave, SS | | 25a. DATE REC'D. BY REGISTRAR
JAN 25 1979 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

10-05010

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02011
REG. NO.1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|--|---|--|---|------------------------------------|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JULES A. GLAUBMAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 23 79 | | | 2b. HOUR
7 ³⁰ A.M. | | | | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 29 28 | | 6. AGE (IN YEARS LAST BIRTHDAY)
50 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
SILVERSPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Executive | | 12b. KIND OF BUSINESS OR INDUSTRY
Clothing Mfg. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
Maryland | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel ----- Glaubman | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence ----- Wolf | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
unknown | | 17. INFORMANT
ADDRESS
Earl Wolf, Potomac, Maryland 20854
10716 Gainsborough Rd. | | | | | |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute MYELOGENOUS LEUKEMIA

2050

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

8 WKS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

NA

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION
NA | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 11/25, 19 78, to 1/23, 19 79, that (1) (we) lost saw the deceased alive on 1-22, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Ralph E. Seligmann | | | | DEGREE
MD | | 22c. DATE SIGNED
1/23/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RALPH E. SELIGMANN | | | | 22e. ADDRESS
8630 Fenton St. Silver Spring, Md. 20910 | | | |

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1-24-79 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Gdn. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church, Virginia | |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Mem. Chap. 1170 Rockvl. Pk. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 26 1979 | | 25b. REGISTRAR'S SIGNATURE
L. K. Brady | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPOSSIBLE: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1/23/79 9:44 AM Cleared by Corcoran - Dr. Kodjia

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BP

11050-05

RECEIVED

11050-05

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02012
REG. NO.

| | | | | | | | | |
|---|--|--|--------|--|--------------|--|--|----------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | JAN. 23 1979 | | | 10:05 PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | |
| Female | | CAUCASIAN | | JULY 12 1890 | | 88 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| CONN | | USA | | | | MONTGOMERY MD | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BETHESDA | | BETHESDA HEALTH CTR | | HOUSEWIFE | | OWN HOME | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| MARYLAND | | SILVER SPRING | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 9342 FRASER ST. | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 17. INFORMANT ADDRESS | | | | |
| (NOT KNOWN) PARTASS | | IVOT KNOWN | | SAME AS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| NO | | UNKNOWN | | MICHAEL F. GREENE - ITEMS # 13 | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a):
4/40
DUE TO, OR AS A CONSEQUENCE OF:
Cardiac Arrhythmia
(b):
Atherosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF:
(c): | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Hypertension | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 8 1975 to Jan 29 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death. | | 22b. SIGNATURE
JOEL GOOZH | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/24/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | |
| JOEL GOOZH | | 4701 RANDOLPH RD #105 ROCKVILLE, MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (CITY OR TOWN COUNTY STATE) | | |
| CREMATION | | 1/24/79 | | CEDAR HILL CREM. | | SUITLAND - PG - MD | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| W.W. CHAMBERS CO. | | SILVER SPRING MD | | JAN 29 1979 | | Creddy | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed in by the funeral director and completely filled in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

12-05015

Released by Dr. Ball

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02013 | |
|---|--|--|--|--|--|---|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR
Donald R. Goldthorpe | | | | | | | | | | REG. NO. | |
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Donald R. Goldthorpe | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-26-79 | | 2b. HOUR
6a M | | | |
| 3 SEX
Male | | 4 RACE
Cauc | | 5 DATE OF BIRTH
MONTH DAY YEAR
8 24 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Minnesota | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Science Writer | | 12b. KIND OF BUSINESS OR INDUSTRY
N.I.H. | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
John - Goldthorpe | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lena - Johnson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
USA WWII | | 17. INFORMANT
Mildred V. Goldthorpe-wife | | ADDRESS
Same as # 13 | | | | | |
| 18 CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>
3352
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Amalgamatic lateral sclerosis</u>
6 years
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Minutes | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-25-79</u> to <u>1-26-79</u> , that (I) (we) lost saw the deceased alive on <u>1-25-79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, _____) | | | | | | | | | | | |
| 22b. SIGNATURE
Joseph A. Romeo | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/26/79 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joseph A. Romeo, M.D. | | | | 22e. ADDRESS
10401 Old Georgetown Rd. Bethesda, Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
1-27-1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | | | | |
| 24. FUNERAL DIRECTOR
J. Wm. Lee's Sons Co. Funeral Home
300-4th St., NE, Washington, D.C. 20002 | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 31 1979 | | 25b. REGISTRAR'S SIGNATURE
Jeffrey McBrady | | | | | |

79-05013

Donald R. Goldthorpe

x

U.S.A.

14 March

Patricia White

007-Pro 4/2/55

x

Patricia

Longmore

14 March

John

Goldthorpe

-

John

-

John

Yes

USA

250-2-071

Patricia V. Goldthorpe - 250-2-071

Washington, D.C.

Lee's Secretary

1-27-1970

Generation

100-4-1-1, Washington, D.C. 20005
Lee's Secretary

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR AIS (4))

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

79-02014

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(Type or print) LORAN First WALDROP Middle Goode Last | | | 2a. DATE OF DEATH
Month 1 Day 11 Year 79 | | | 2b. HOUR
1055 A M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
SEPT. 3. 1904 | | 6. AGE (In years lost birthday)
74 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | |
| 10. CITY OR TOWN OF DEATH
OLNEY | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Beaumont Grove | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
SHEET METAL WORKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | | 13b. COUNTY
MONT | | 13c. CITY OR TOWN
WHEATON | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First JOHN Middle GOODE Last CLAPTON | | 15. MOTHER'S MAIDEN NAME First LULAH Middle CLAPTON Last | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) No (If yes give war or dates of service) | | | |
| 16b. SOCIAL SECURITY NO.
214-12-7822 | | 17. INFORMANT Address HELEN E. GOODE 11504 AMHERST AVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INANITION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 Hrs.
Conditions, if any, which gave rise to immediate cause (a): C.N.S. DEGENERATION 4 YRS.
stating the underlying cause (b) ALZHEIMER'S DEMENTIA 4 YRS.
last. (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
ARTERIOSCLEROTIC VASCL DISEASE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/10/76 , 19 76 , to 1/11/79 , 19 79 , that (I) (we) last saw the deceased alive on 1/9/79 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Donald R. Lewis DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/11/79 | | | |
| 22d. PHYSICIAN'S NAME (Type)
D. R. LEWIS MD | | 22e. ADDRESS
OLNEY MD 20832 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 15, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Carroll's Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Rockville. mont MD | |
| 24. FUNERAL DIRECTOR
Takoma F.H. Inc. (J.A. Walters) | | 25a. ADDRESS
Washington St. N.W. | | 25a. REC'D BY REGISTRAR
DATE JAN 18 1979 | | 25b. REGISTRAR'S SIGNATURE
John J. McCreedy | |

3909

#1050-02

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02015
REG. NO.1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ROBERT T GOODMAN | | | 2a. DATE OF DEATH
MONTH 1 DAY 18 YEAR 79 | | 2b. HOUR
3:46 PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
June 2, 1931 | | 6. AGE (IN YEARS LAST BIRTHDAY)
47 | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Forman | | 12b. KIND OF BUSINESS OR INDUSTRY
Construction |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE Maryland COUNTY Montgomery CITY OR TOWN Sil. Spring | | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST Clint MIDDLE B. LAST Goodman | | | 15. MOTHER'S MAIDEN NAME
FIRST Gladys MIDDLE Littrell LAST Littrell | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO.
224-32-4289 | | 17. INFORMANT
Maxine B. Goodman-wife-(same as 13e) | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) Bronchopneumonia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Carcinoma of Lung | | 3 years |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Mar 19 78 , to 11/18 19 79 , that (I) was lost saw the deceased alive on 11/18 19 79 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I will did) did not view the body after death. | | | | | |
| 22b. SIGNATURE
G. Leonard Gold, MD | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
11/19/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G. Leonard Gold, MD | | 22e. ADDRESS
8630 Fenton Street, Silver Spring, Md | | | |

| | | | |
|--|-----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Jan. 22, 1979 | 23c. NAME OF CEMETERY OR CREMATORY
Ridgedale Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Smyth Va. |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc.
8434 Ga. Ave., S.S. Md | | 25a. DATE REC'D. BY REGISTRAR
JAN 24 1979 | 25b. REGISTRAR'S SIGNATURE
Clark E. White |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified alone.

51050-27

0501 1344L

1944

72-05012

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-02016

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ROSENA A. Gormley | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 15, 1979 | | | 2b. HOUR
3:02 AM | | | |
| 3. SEX
female | | 4. RACE
caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 5, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Bath, Maine | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
at home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET ADDRESS
10120 Grant Avenue | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Tracey | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rose Lundigan | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | | 16b. SOCIAL SECURITY NO.
unavailable | | 17. INFORMANT
ADDRESS
Owen P. Gormley-son 7721 Warbler Lane, Derwood, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
485-
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebral anoxia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) Bronchopneumonia | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 min
12 hr.
48 hr. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Cerebral thrombosis with hemiplegia, ASHD, Diabetes mellitis | | | | | | | | | |
| 19a. DATE OF OPERATION
12-19-78 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Gangrene Right Leg | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 13, 1978 , to Jan 15, 1979 , that (I) (we) last saw the deceased alive on Jan 14, 1979 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
James R. Moore Jr. | | | | DEGREE
MD | | | | 22c. DATE SIGNED
1-15-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James R. Moore Jr. MD | | | | 22e. ADDRESS
207 Brookes Ave Gaithersburg Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 19, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Calvary Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
South Portland, Maine | | | |
| 24. FUNERAL DIRECTOR
NAME
Hysong Funeral Home 1300 N St. N.W. Washington, D.C. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 18 1979 | | 25b. REGISTRAR'S SIGNATURE
Jeffrey McCreedy | | | |

79-02018



A. Rosen A. Rosen

July 2, 1952

conclusion

Letter

x

W. A. A.

John, Maine

x

Silver Spring

Monterey

Harvard

Rose

Tracy

Thomas

unavailable

no

Calvary Cemetery

Jan. 19, 1979

Burial

Hyattsville Home 1300 N. St. N.W. Washington, D.C.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-02017

| | | | | | | | | | | |
|---|--|--|--|---|---|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Carol Margaret Graham | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 11, 1979 | | | 2b. HOUR
8:48AM | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
November 12, 1936 | | 6. AGE (IN YEARS LAST BIRTHDAY)
42 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT INSUCH FACILITY, GIVE STREET ADDRESS)
Clinical Center, NIH, Bethesda | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
REGISTERED NURSE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ARTHUR H. KINSINGER | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGARET J. RITTER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
200-28-2460 | | 17. INFORMANT
ADDRESS
Herbert B. Graham 9212 Woodland Dr. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) <u>Hepatic and renal failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Carcinoma of breast, Metastatic to</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>liver and bone</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 28, 1978</u> , to <u>January 11, 1979</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>January 11, 1979</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Edward Bradley</i> | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
1/11/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDWARD BRADLEY | | | | | | 22e. ADDRESS
National Institutes of Health
Clinical Center, NIH, Bethesda, Md 20014 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
1/15/79 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>Frederick Hardy</i> | | |
| 26. 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

79-05017

TELEPHONE

U.S.A.

REGISTERED

MONTGOMERY

ARTHUR H.

KINSMAN

MARGARET J.

CITIZEN

NO

BURIAL

1/17/79

GATE OF HEAVEN

STREET

FRANCIS J. COLLIS

JAN 12 1979

500 W. 11th St. ST. LOUIS, MO. 63101

NAME: Edmund L. Green

DATE OF DEATH: January 12, 1979

PLACE OF DEATH: Montgomery County

SEE: #79-04669
February, 1979
Montgomery County

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02018
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|--|---|-----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Charles Lewis Gregory | | | 2a. DATE OF DEATH
MONTH 1 DAY 21 YEAR 79 | | 2b. HOUR
2:15A.M. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH Nov. DAY 22 YEAR 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Kansas | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Exec.-Pres. | | 12b. KIND OF BUSINESS OR INDUSTRY
Cycles & Sports | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Takoma Park | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
6617 Eastern Avenue | | | |
| 14. FATHER'S NAME
FIRST (Unknown) MIDDLE LAST Gregory | | | | 15. MOTHER'S MAIDEN NAME
FIRST Susan MIDDLE LAST Bruner | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW II | | 17. INFORMANT
Pearl R. Gregory, Wife, Same as # 13. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular Fibrillation
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Ischemic Cardiomyopathy
DUE TO, OR AS A CONSEQUENCE OF
(c) Coronary Heart Disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 yrs
7 yrs | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Diabetes | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 23 , 19 73 , to January 25 , 19 79 , that (I) (we) last saw the deceased alive on 1/16 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Gerald I. Shugall DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/22/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gerald I. Shugall | | | | 22e. ADDRESS
5530 Wis. Ave., Washington, D.C. 20015 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/24/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
JOSEPH CAWLER'S SONS INC.
ADDRESS
6130 WISC. AVE., N. W. WASH., D. C. 20018 | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 24 1979 | | 25b. REGISTRAR'S SIGNATURE
Robert McBratney | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medic examiner must be notified at once.

MEDICAL CERTIFICATION

81050-05



Charles Lewis Gregory

Washington Adolescent Association
Montgomery County

(10002)

147218

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02019

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Ward Willson GRIFFITH III | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 22 1979 | | | 2b. HOUR
6:40 PM | | | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 7 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Naval Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U. S. Navy | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't | |

| | | | | | | | | | | |
|---|--|--|---|--|-------------------------------|---|---|--|--|--|
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6313 Carnegie Drive | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ward Willson Griffith Jr. | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Margaret Nickles | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes 1941-62 | | | | |
| 16b. SOCIAL SECURITY NO.
579 52 8947 | | | 17. INFORMANT
ADDRESS
Bethesda, Md.
Ronald W. Griffith 6313 Carnegie Dr. | | | | | | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Respiratory Failure
3352
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) ALS
(c) Due to, or as a consequence of | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

| | | | | | | | |
|---|--|--|--|---|--|--------------------------------------|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 21</u> , 19 <u>79</u> , to <u>Jan. 22</u> , 19 <u>79</u> , that (I) (we) lost above, (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<i>Jean Panagakos MD</i> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>23 Jan 79</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jean Panagakos MD | | 22e. ADDRESS
National Naval Medical Center, Bethesda, Md. | | | | | |

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/26/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Arlington Va. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Robt. A. Pumphrey Funeral Home, Bethesda, Maryland | | 25a. RECEIVED BY REG. NO. 1979 25b. REGISTRAR'S SIGNATURE | | | | | |

79-02019

| | | | | | |
|------------------|-------------------------------|--------------|--------------------------------------|-----------------|-------|
| Male | Classical | July 7 1912 | 50 | January 22 1979 | 6:40P |
| Washington, D.C. | USA | | | | |
| Postcard | National Naval Medical Center | U.S. Navy | | | |
| Maryland | Montgomery | Bethesda | x | | |
| World | Willson | Griffith III | Alice | | |
| Yes | 1941-C2 | 579 32 8947 | Donald W. Griffith 6712 Carnegie Dr. | | |

XX X

Jan. 22 79
Jan. 21 79

XX

National Naval Medical Center, Bethesda, Md.

Dr. A. Humphrey Funeral Home, Bethesda, Maryland
Washington National

3206
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-02020 | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | | 2c. MIN | |
| | | Philippine | | Gross | | 1-9-79 | | 12 | | 00 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| Female | | Caucasian | | October 7, 1886 | | 92 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Vienna, Austria | | USA | | | | Montgomery | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Bethesda | | Suburban Hospital | | Housewife | | Home | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| Maryland | | Montgomery | | Silver Spring | | | | | | 13105 Ideal Drive | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| Friedrich | | Krebs | | Kathi | | Meisel | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | 080-18-9203 | | Mrs. Fritzi Gross | | 13105 Ideal Drive | | | | Silver Spring, Md. 20906 | |
| MEDICAL CERTIFICATION | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Residual C.V.D.</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | 4292 | | | | | | | | 3 days | |
| | | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | 10 years | |
| | | | | | | | | | | 1 year | |
| | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | 22a. I certify that (I) (the hospital) attended the deceased from <u>1975</u> , 19____, to <u>1/9/79</u> , 19____, that (I) (we) last saw the deceased alive on <u>1/9/79</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| LAURENCE J. THOMAS | | 11801 ROCKVILLE PIKE | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 1-11-79 | | Woodlawn Cemetery | | Bronx, New York | | | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE RECEIVED BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Danzansky-Goldberg Mem. Chap. Rockville, Md. | | 1170 Rockville Pk. | | | | JAN 12 1979 | | | | | |

05050-05

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02021 | | | | |
|---|--|--|--|--|--|--|--|--|--|--|-----|--|----------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| Glenn H. Grow | | | | | | | | 1-10-79 | | | | | 9:25A M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | |
| male | | white | | Nov 6, 1892 | | 86 | | MONTHS | | DAYS | | HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| Michigan | | USA | | | | Montgomery MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Takoma Park | | Washington Adventist Hospital | | | | | | | | Saw Mill operator | | Retired | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | |
| Md | | Pro George | | Hyattsville | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 6900 23rd Place | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | | |
| Herbert E Grow | | | | Mary E McKinney | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | |
| no | | | | 223 24 8413A | | Willis G Grow | | Hyattsville, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY. | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Bronchopneumonia, Congestive Cardiac Failure</u> | | | | | | | | | | | | | | |
| 496- DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | |
| (b) <u>C.O.P.D.</u> <u>A.S.T.D</u> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| <u>Carcinoma Prostate</u> | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY | | | | 21f. LOCATION | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/9/79</u> , 19 <u>79</u> , to <u>1/9/79</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1/9</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | | | | |
| <u>[Signature]</u> | | | | | | | | <u>[Signature]</u> | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | | |
| V.C. VAID | | | | 7676 New Hampshire Ave | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | |
| Burial | | | | Jan 12, 1979 | | Cedar Hill Cemetery | | Sutland Pro Georges STATE | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| P. Gasch's Sons P A Hyattsville Md. | | | | JAN 16 1979 | | | | <u>[Signature]</u> | | | | | | |

15050-25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-02022 |
|---|--|--|--|---|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Hilda B Guenther | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1 22 79 | | 2b. HOUR
4 P M | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
1 11 94 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | |
| 10. CITY OR TOWN OF DEATH
Sandy Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRIENDS House Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sandy Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13. STREET ADDRESS
17340 Quaker Lane, | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William Bender | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Flora Koehnig | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
none | | 17. INFORMANT
Morgan W. Guenther-son-Dr. Brookville, Md. | | ADDRESS
19401 DuBarry | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Brain aneurysm</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain aneurysm</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Organic Brain Syndrome</u>
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 hrs
3 mo
years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 6/22 1976 to 1/23 1979, that (1) (he) lost saw the deceased alive on 1/23 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (do not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
H. H. van der | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/22/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
H. H. van der | | | | 22e. ADDRESS
18111 P. P. Highway Dr. Chevy Chase 20832 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Jan. 23-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory Alex., Fairfax Va. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR NAME
Warner E. Pumphrey, Inc. | | | | 24b. ADDRESS
8434 Ga. Ave., S.S. Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 26 1979 | | 25b. REGISTRAR'S SIGNATURE
L. H. H. H. | | |

18-02055

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44

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RECEIVED
FEB 11 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02023
REG. NO. | |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Alice F. Hadesty | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 18, 1979 | | | | 2b. HOUR
12:33 PM | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
APRIL 27, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GERMANY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
GAITHERSBURG | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
403 W. DIAMOND AVENUE | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ADOLPH SCHULTZ | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | 16b. SOCIAL SECURITY NO.
179-16-6768 | | 17. INFORMANT
SON ADDRESS OLNEY, MARYLAND
WILLIAM HADESTY, 18929 CROVERHILL LANE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
410- DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 HOURS
YRS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Anemia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/15/78, 19, to 1/18, 1979, that (I) (we) last saw the deceased alive on 12/29, 1978, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Cheryl Winchell MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/18/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Cheryl Winchell | | | | | | 22e. ADDRESS
19241 Montgomery Village Ave | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
1/22/79 | | 23c. NAME OF CEMETERY OR CREMATORY
CHRIST CHURCH CEMETERY | | 23d. LOCATION
CITY OR TOWN STATE
FOUNTAIN SPRINGS MD | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 19 1979 | | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Dorothy McBrady | | | | | |

MEDICAL CERTIFICATION

BP

10-05053

GERMAN
U.S.A.
WHITE
APRIL 17, 1903

MUSKIE

WATSON CALIFORNIA
403 N. DAWSON AVENUE

ADOLPH
SCHULTZ
179-12-2788
WILLIAM WADSWORTH, 1899 GROVERVILLE LINE
SON
OTHER, WADSWORTH

500 RIV. BLVD. W. SILVER SPRING, MD. 20901
FRANK J. COLLINS
CHRIST CHURCH, CHARTERS, WASHINGTON, D.C.
FOUNTAIN SPRING, MD.

CERTIFICATE OF DEATH

79-02024

| | | | | | | | | | | | |
|--|--|---|--|---|---------------------------------------|---|---|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) RUTH REBECCA HALL | | | 2a. DATE OF DEATH
Month 7 Day 13 Year 79 | | | 2b. HOUR
8:45 A M | | | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
9-12-1898 | | 6. AGE (In years last birthday)
80 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
10005 Greenock Road | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spr. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
10005 Greenock Road | | |
| 14. FATHER'S NAME
First Alexander Middle Higgs Last | | | 15. MOTHER'S MAIDEN NAME
First Anna Middle Wilkinson Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) no (If yes give war or dates of service) none | | | 16b. SOCIAL SECURITY NO.
579-32-8557 | | | 17. INFORMANT
Address 617 Yarmouth Jacqueline R. Myers-dau-Ave Absecon, NJ | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
4292
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
CHRONIC PULMONARY DISEASE, CHRONIC URINARY TRACT INFECTION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year 19
P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June , 19 60 , to June 13 , 19 79 , that (I) (we) last saw the deceased alive on Dec 19 78 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Bernard A. Fitzgerald | | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
1-13-79 | | |
| 22d. PHYSICIAN'S NAME (Type)
BERNARD A. FITZGERALD | | | | | | 22e. ADDRESS
217 UNIVERSITY BLVD E, SILVER SPRING, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
Jan. 17, 1979 | | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet | | | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. | | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | | | | | ADDRESS
8434 Ga. Ave., S.S. Md. | | | 25a. REC'D BY REGISTRAR
JAN 15 1979 | | |
| | | | | | | DATE | | | 25b. REGISTRAR'S SIGNATURE
 | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED WITH MEDICAL EXAMINER

42050-02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers Pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-02025

| | | | | | | | | | | | |
|--|--|--|---|--|-----------------------------------|--|-------------------|--|------|--|----------|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| | | Felecia | | | | Hamilton | January | 4 | 1979 | 8 ¹⁰ | P.M. |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| FEMALE | WHITE | MONTH DAY YEAR
10 7 84 | | 94- YRS. | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| New Castle, PA | U.S.A. | | | Montgomery | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Bethesda | Carriage Hill-Bethesda | | Secretary | | U.S. Gov't. | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| D.C. | | | | Washington | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 1954 Columbia Rd. N.W. | | Wash., D.C. | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST | | MIDDLE | | LAST | | FIRST | | MIDDLE | | LAST | |
| James | | M. | | Hamilton | | Mary | | E. | | Taylor | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | ADDRESS | |
| No | | | | 172-10-6609 | | James C. McKay-Attorney-888 | | | | 16th St. N.W. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) myocardial infarction | | | | | | | | | | | |
| 410- DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | | | |
| 22a. I certify that (a) this hospital attended the deceased from June 1978, to Jan 1979, that (b) (we) lost saw the deceased alive on Jan 3 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (c) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| William E. Hurwitz | | | | MD | | | | 1/4/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| William E. Hurwitz | | | | 1852 Columbia Rd. N.W. Wash DC | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 1/8/79 | | Oak Park Cemetery | | New Castle, Penn. | | | |
| 24. FUNERAL DIRECTOR'S NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Joseph Gawler's Sons, Inc. | | | | JAN 12 1979 | | | | | | | |
| 5130 Wisc. Ave. N.W. Wash., D.C. | | | | | | | | | | | |

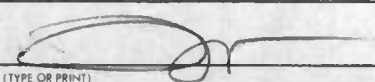
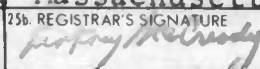
25050-05

William E. Brewster

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-02026 | | | | | |
|---|--|---|--|--|---|--|---|---|--|---|--|--|--|------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Konradine (NMI) Hampe | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1 11 79 | | 2b. HOUR
10.55 a M | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
May 26, 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 74 HRS HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Massachusetts | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bethesda Health Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
617 Dearhead Court | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Henry J. Hampe | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Anna K. Ulrich | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
033-16-8574A | | 17. INFORMANT ADDRESS
1106 Laguna Lane Robert Hampe, Gulf Breeze, Fla. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Terminal cerebral thrombosis
4340
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
year | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
_____ | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
_____ | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/32 , 19 76 , to 1/11/79 , 19 _____, that (I) (we) last saw the deceased alive on 1/10/79 , 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE  | | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1/11/79 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
OSOOTH LEXAGUL | | | | | 22e. ADDRESS
7425 Aulington Rd, Bethesda Md | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1-16-79 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Joseph's Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Boston, Massachusetts | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME
ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1979 | | 25b. REGISTRAR'S SIGNATURE
 | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

79-02027

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print)
First Middle Last
Hampson, AGNES MARY HAMPSON | | | 2a. DATE OF DEATH
Month Day Year
11/24/79 | | | 2b. HOUR
8:55 AM | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MARCH 1, 1894 | | 6. AGE (In years last birthday)
84 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
1204 TANLEY ROAD | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOME MAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
1204 TANLEY ROAD | |
| 14. FATHER'S NAME First Middle Last
TIMOTHY REGAN | | | 15. MOTHER'S MAIDEN NAME First Middle Last
JOHANAH REAGAN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
NO | | 16b. SOCIAL SECURITY NO.
214-74-6929 | | 17. INFORMANT
SON | | Address GAITHERSBURG, MD. | | | |
| | | | | ROBERT E. HAMPSON, JR. | | 18913 WHETSTONE CIR. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral arteriosclerosis & Cerebral Infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Generalized arteriosclerosis and
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerosis Heart Disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Several years at least 5 | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Metastatic Carcinoma, Primary Site undetermined | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/8/73 , 19__, to 11/24/79 , 19__, that (I) (we) lost the deceased on 11/23/79 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
John J. Sweeney MD | | | | DEGREE
MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
11/24/79 | |
| 22d. PHYSICIAN'S NAME (Type)
John J. Sweeney | | | | 22e. ADDRESS
1905 Gatewood Rd SS and | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
1/27/79 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION (City or Town) (County) (State)
SILVER SPRING MONT MD. | | | |
| 24. FUNERAL DIRECTOR
FRANCIS J. COLLINS | | | | ADDRESS
500 LINTV. BLVD. W. SILVER SPRING, MD. 20901 | | 25a. REC'D BY REGISTRAR
JAN 29 1979 | | 25b. REGISTRAR'S SIGNATURE
Patricia A. Cready | |

79-05057

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02028
REG. NO.

| | | | | | | | |
|--|---|--|---|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | LAST | | |
| Edward L. Hanson | | 1-23-79 | | 12 | 40 | | PM |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Male | White | MONTH DAY YEAR | | 72 YRS | | IF UNDER 2 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Montomence, Ill. | U.S.A. | | | Montgomery City | | MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda Md. | Suburban Hospital | | Merchandising | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 17625 Moore Rd. | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | |
| August Montgomery Dickerson | | Stella Lamport Hanson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | 337-18-6735 | | Ethel Bissell Hanson 17625 Moore Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 5809 RENAL FAILURE | | | | | | | 10 DAYS |
| ACUTE GLOMERULONEPHRITIS | | | | | | | UNK |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 70 to 1-27 19 79, that (I) (we) last saw the deceased alive on 1-23 19 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| D.L. Bucy | | MD | | 1-24-79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| D.L. Bucy / SN Jones | | 809 Veirs Mill Rd | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | Jan. 27, 1979 | | Oak Hill Cem. | | Waukega Iroquois Ill. | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE OF REGISTRATION | | 25b. REGISTRAR'S SIGNATURE | |
| G. Douglas Stauffer | | Rt. 10 Box 66 Fred., Md. | | JAN 29 1979 | | | |

BP

85050-07

CERTIFICATE OF DEATH

79-02029

| | | | | | | | | | | | |
|---|--|------------------------------|--|--|------|--|---|--|--|------------------------|------------------------------|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR | | |
| Josephine G. Hash | | | | | | 1-10-1979 | | | 3:45P M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN |
| Female | | White | | Oct. 29, 1893 | | | 85 YRS. | | | | 5 35 |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Wash., D.C. | | U.S.A. | | | | Mont. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Silver Spring | | | 1402 - Gleason St. | | | Housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | Mont. | | | Silver Sp. | | | | 1402 - Gleason St. | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| James M. Ward | | | | | | Josephine M. Jones | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| no | | | 212-74-8027 | | | Eleanor L. Spilman (Dtr.) | | | same as above | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Congestive heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>days</u>
<u>months</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1970</u> , 19 <u>70</u> , to <u>Jan 10, 1979</u> , that (I) (we) last saw the deceased alive on <u>Jan 10, 1979</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>A.W. Smith M.D.</u> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>1/16/79</u> | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>A.W. SMITH</u> | | | | | | 22e. ADDRESS
<u>13018 George Ave
White Station, Md. 20906</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 1-13-79 | | Cedar Hill Cem. | | | Suitland Pr. Geo. | | | Md. | |
| 24. FUNERAL DIRECTOR
ADDRESS
<u>Nalley's F.H. Inc. Mt. Rainier, Md.</u> | | | | | | 25a. REC'D BY REGISTRAR
DATE
<u>JAN 16 1979</u> | | | 25b. REGISTRAR'S SIGNATURE
<u>Mary M. Brady</u> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02030
REG. NO. | | | |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
EVA JANE HASTINGS | | | | 2b. HOUR 1 P. M. | | | |
| 3. SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
August 1889 | | 6 AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10 CITY OR TOWN OF DEATH
GAITHERSBURG | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
H. Wilson Health Care Center 301 Russell Ave. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
late Jacob | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
late Mollie | | 13e. STREET ADDRESS
301 Russell St. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mrs Alice Maulsby 225 Stoney Ford RD. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 436- CEREBRO-VASCULAR ACCIDENT
(b) DUE TO, OR AS A CONSEQUENCE OF, ARTERIOSCLEROSIS
(c) DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 WKS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Feb. 19 76, to JAN 19 79, that (I) (we) last saw the deceased alive on 1-16 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Thos G Ward M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/23/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thos. G. WARD, | | | | 22e. ADDRESS
6116 Robinwood, Bethesda, Md 2003x | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Jan 24, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Memorial Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Catonsville Maryland | |
| 24 FUNERAL DIRECTOR NAME
Harry H. Witzke | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 26 1979 | | 25b. REGISTRAR'S SIGNATURE
Harry H. Witzke | |

72-05030

4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02031
REG. NO. | |
|---|--|---|--|---|--|--|--|--|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Dorothea (Dorothy) V. HATCH | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 4 1979 | | | 2b. HOUR
2:30P M | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 21 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66
YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Massachusetts | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Naval Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
XXXXXX HOMEMAKER XXXXXXXX | | 12b. KIND OF BUSINESS OR INDUSTRY
XXXXXX | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3702 Marble ArchWay | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter V. Scanlan | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hulda Naomi Bergman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
021-10-8626 | | 17. INFORMANT
Henry B. Hatch | | 17a. ADDRESS
See item 13 | | 17b. RELATIONSHIP
HUSBAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest
410- DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) probable myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
memoria | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 1 , 19 79 , to January 4 , 19 79 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 4 , 19 79 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Martin W. Jones DO | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5 Jan. 1979 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Martin W. Jones, D. O. | | | | 22e. ADDRESS
National Naval Medical Center, Bethesda, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
1/8/79 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | | 24b. ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | 25a. DATE REC'D. BY REGISTRAR
JAN 8 1979 | | 25b. REGISTRAR'S SIGNATURE
Robert M. Brady | | | |

MEDICAL CERTIFICATION

29

1

58

27

35

150

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Figure 1. (continued)

2520

— 255 —

2047

Abstract

07/8/11

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02032
REG. NO.1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | |
|---|--|---|--|---|------------------------------|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Geraldine W. Haupt | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 22, 1979 | | 2b. HOUR
7:11 P.M. | | | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 25 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
79 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
79 | | 8. IF UNDER 24 HRS.
HOURS MIN.
79 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penn | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Physicis | | 12b. KIND OF BUSINESS OR INDUSTRY
Bur. Stand | | | | | |
| 13a. STATE
Md | | | | | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
S.S. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3170 Adderly Court | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel George Walker | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Elizabeth Kline | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
578 58 7959 | | 17. INFORMANT
ADDRESS
Husband
Ralph F. Haupt Same as above | | | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Acute Myocardial Infarction** 410-
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) **Coronary artery disease**
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
8 hours

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>1-22</u> , 19 <u>79</u> , to <u>1-22</u> , 19 <u>79</u> , that (1) (we) lost
saw the deceased alive on <u>1/22</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Alberto Rotsztain</i> | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Alberto Rotsztain, M.D. | | 22e. ADDRESS
Reemore Medical Center 3701 Rosemoir Blvd.
Silver Spring Md 20906 | | | | | |

MEDICAL CERTIFICATION

Medical Examiner notified by J. Beatty, R.N. 8:35 p.m. 1-23-79

| | | | | | | | |
|--|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/25/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery Suitland | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
PG Md. | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi F.H. | | | | ADDRESS
11800 N.H.Ave. Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR 75b. REGISTRAR'S SIGNATURE
JAN 26 1979 | |

19-02032

| | | | | | | | | | | | | | | | | | | | |
|------|---------------------|-----|-------------|-----|------|-----|-----|-----------|-------|----------|------|-----------|-------------|------------|------|-----------|--------------------|---------|-------------------------|
| NAME | George Walker | SSN | 278 58 7952 | DOB | 1928 | POB | USA | ETHNICITY | White | RELIGION | None | EDUCATION | High School | EMPLOYMENT | None | RESIDENCE | 3170 Address Court | CONTACT | Ret. Physical Therapist |
| NAME | Ann Elizabeth Kline | SSN | | DOB | | POB | USA | ETHNICITY | White | RELIGION | None | EDUCATION | High School | EMPLOYMENT | None | RESIDENCE | 3170 Address Court | CONTACT | Ret. Physical Therapist |

1/25/79 Cedar Hill Cemetery, Suite 200, 11800 N.E. 11th Ave., Silver Spring, MD



1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02033
REG. NO.

| | | | | | |
|---|--|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Stella Ruth Hawkins | | | 2a DATE OF DEATH
MONTH DAY YEAR
Jan 30 1979 | | 2b HOUR
11:00 AM |
| 3 SEX
Female | 4 RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPT 16 1882 | | 6 AGE (IN YEARS LAST BIRTHDAY)
96 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
CARLETON HILL BETHESDA
5215 Cedar Lane | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK
INTERNAL REVENUE | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOV'T. |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
13b. COUNTY
13c. CITY OR TOWN
WASH. D.C. | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1921 37TH STREET NW |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Adolph Ruth | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clara E. Bieling | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
579 073604 | | 17. INFORMANT
ADDRESS
2353 GREENWICH S. FALLS CHASE MD.
CATHERINE CRUTH SISTER IN LAW | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Arteriosclerosis
4409
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 11-22, 1978, to 1-30, 1979, that (I) (the) lost saw the deceased alive on 1-29, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | |
| 22b. SIGNATURE
James W. Egan | | DEGREE
M.D.
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-30-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES W. EGAN | | 22e. ADDRESS
5413 Cedar Ln. - Bethesda, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-2-79 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEM | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
5413 AND MARYLAND | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
FEB 5 1979 Anthony McCrady | | | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
John F. Dettel DEVLB FUNERAL HOME WASH. DC. | | | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

72-05033

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 7/77
(VR A 15 (4))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | 79-02034
REG. NO. | | | |
|---|--|------------------------------|--|--|--|--|--|--|--|--|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR | | | | | | 2a. DATE OF DEATH | | | | | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | 2a. DATE OF DEATH | | | | | | MONTH DAY YEAR | | 2b. HOUR | |
| Clayton Curtiss Hays, Jr. | | | | | | 1-11-1979 | | | | | | 10:10 P.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS (LAST BIRTHDAY)) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | |
| MALE | | WHITE | | MONTH DAY YEAR | | 61 | | MONTHS DAYS | | HOURS MIN | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Va. | | Amer. | | | | Montgomery | | | | | | MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Takoma Park | | | | Washington Adventist Hosp | | | | Retired | | | | Machine Shop Supervi | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | |
| Virginia | | Shenandoah | | Strasburg | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Fort Valley Rte-Box 30-P | | | | | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | | | | | | | | |
| Clayton Curtis Hays, Sr. | | | | | | Minnie De Lung | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | | |
| Yes | | | | WWII | | 579 03 3052 Agnes E. Hays (spouse) Same as #13 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <u>Renal failure</u> | | | | | | | | | | | | Weeks | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> | | | | | | | | | | | | years | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u> | | | | | | | | | | | | years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Severe gen ASD; 2 previous MI's; 2 CVA's</u> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 11/17/78 | | | | Resection part anastomosis | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> 19 <u>78</u> to <u>1/11</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1/11</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | | | | 22c. DATE SIGNED | | | |
| <u>Bennett Crige M.D.</u> | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 1/12/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | | | | | |
| Kenneth Cruze, M.D. | | | | | | 831 University Blvd East, Sil. Spr Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | | 15 Jan 1979 | | Washington National Suitland | | | | PG Md | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert E. Wilhelm Funeral Home Suitland, Md. | | | | | | JAN 17 1979 | | | | | | <u>Patrick McCready</u> | | | |

MEDICAL CERTIFICATION

29

48050-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|---|--|---|---|--|
| 1. FOR STATE REGISTRAR <u>Blanche Henderson</u> | | 79-02035
REG. NO. | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
<u>Blanche Henderson</u> | | | | | 2a DATE OF DEATH MONTH DAY YEAR
<u>1 04 79</u> | | | 2b HOUR
<u>1:28 P M</u> | |
| 3 SEX
<u>F</u> | | 4 RACE
<u>Negro</u> | | 5. DATE OF BIRTH MONTH DAY YEAR
<u>March 14, 1903</u> | | 6 AGE (IN YEARS LAST BIRTHDAY)
<u>75</u> YRS | | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Maryland</u> | | 7b CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery</u> MD. | | | |
| 10 CITY OR TOWN OF DEATH
<u>Silver Spring</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Holy Cross Hospital</u> | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Housewife</u> | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a STATE
<u>D. C.</u> | | 13b COUNTY
<u>Washington</u> | | 13c CITY OR TOWN
<u>Washington</u> | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
<u>1515 Van Buren Street, N. W.</u> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
<u>Louis Wesley Pinkney</u> | | | | | 15 MOTHER'S MAIDEN NAME MIDDLE LAST
<u>Martha Fletcher</u> | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<u>NO</u> | | 16b SOCIAL SECURITY NO.
<u>Not Stated</u> | | 17 INFORMANT ADDRESS
<u>James L. Pinkney, Son, P.O. Box 2304, Hartford, Conn</u> | | | | | |
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>
436-
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>D. & B. Mellitus</u> | | | | | | | | | |
| 18a DATE OF OPERATION | | 18b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 19a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 19b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<u>P.M. 19</u> | | 20c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21a INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>April 26</u> , 19 <u>78</u> , to <u>114</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>114</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
<u>G. J. J. J.</u> | | DEGREE
<u>M.D.</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c DATE SIGNED
<u>11/4/79</u> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
<u>EDGAR H. LEVIA</u> | | | | 22e ADDRESS
<u>8630 Fenelon St.</u> | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | 23b DATE
<u>9 Jan 79</u> | | 23c NAME OF CEMETERY OR CREMATORY
<u>Lincoln Memorial Cemetery, Suitland, Maryland</u> | | 23d LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24 FUNERAL DIRECTOR NAME
<u>JACVIS F.H. 1432 York St. N.W. D.C.</u> | | | | 25a DATE REC'D. BY REGISTRAR
<u>JAN 16 1979</u> | | 25b REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

10-05032



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02036
REG. NO.

| | | | | | | | | | | |
|---|--|---|--|--|----------------|---|--|---|---------------------|--------------------------------|
| 1. FOR
STATE
REGISTRAR | | 1 DECEASED NAME
(TYPE OR PRINT) | | FIRST
ROBERT | MIDDLE
NEEL | LAST
HENDERSON | 2a. DATE OF DEATH MONTH DAY YEAR
January 8, 1979 | | 2b. HOUR
10:05am | |
| 3 SEX
Male | | 4 RACE
white | | 5 DATE OF BIRTH
MONTH DAY YEAR
Oct. 11, 1894 | | 6 AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO. MD. | | | | |
| 10 CITY OR TOWN OF DEATH
SANDY SPRING, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRIENDS HOUSE NURSING HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Elec. Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
Eng. | | |
| 13a. STATE
Md. | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Sandy Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
Quaker Lane | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Joseph F. Henderson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lydia B. Wagner | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
579-10-0529 | | 17. INFORMANT ADDRESS
Alex.
Charles B. Henderson 314 Mansion Dr. Va. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>
4392
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Anterior subarachnoid hemorrhage</u>
20 yrs
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 hr | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Jan 19 58, to Jan 19 79, that (I) (we) lost
saw the deceased alive on 1/4/79 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
A.D. Bonkfaht | | | | DEGREE
M.D.
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/8/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A.D. Bonkfaht | | | | 22e. ADDRESS
18111 Prince Philip Dr. Otway, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
Jan. 9, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee Crematory | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | | |
| 24 FUNERAL DIRECTOR
NAME
Francis H. Barber | | | | ADDRESS
Laytonsville, Md. 20760 | | 25a. DATE REC'D. BY REGISTRAR
JAN 9 1979 | | 25b. REGISTRAR'S SIGNATURE
Rifley McCuskey | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-05038

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02037
REG. NO. | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
LEONARD CARLOS HERRON | | | | 2a. DATE OF DEATH MONTH DAY YEAR
January 15, 1979 | | | | 2b. HOUR
1:05P M | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
December 25, 1939 | | 6 AGE (IN YEARS LAST BIRTHDAY)
39 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
W. Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Clinical Center, NIH, Bethesda | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Drilling | | 12b. KIND OF BUSINESS OR INDUSTRY
Natural gas | | | |
| 13a. STATE
West Virginia | | | | 13b. COUNTY
Weston | | 13c. CITY OR TOWN
Weston | | 13d. STREET ADDRESS
Route 3, Box 26004 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Clarence Herron | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Alma Hilborn | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
Vietnam 232-64-2467 | | 17. INFORMANT ADDRESS
Deloris Herron same as 13e | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Malignant Melanoma metastatic to lungs
DUE TO, OR AS A CONSEQUENCE OF
(c) pleura, lymph nodes, skin and muscle | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
4 years | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 14, 1979 , to January 15, 1979 , that (I) (we) lost saw the deceased alive on 19 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | | | DEGREE H.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
1/15/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. O. Foote MD | | | | 22e. ADDRESS
National Institutes of Health, Clinical Center, Bethesda, Md 20014 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
1/18/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Upshur Co. Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Buckhannon, W.Va. | | | |
| 24 FUNERAL DIRECTOR NAME
Robert A. Pumphrey Funeral Homes, P.A. | | | | 24b. ADDRESS
Bethesda, Maryland | | 25a. DATE REC'D. BY REGISTRAR
JAN 22 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

BP

19-05037

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

79-02038

| | | | | | | | | | |
|---|--|---|---|---|--|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) Elizabeth I. Hess | | | 2a. DATE OF DEATH
Month Day Year
January 15 1979 | | | 2b. HOUR
4:40 P.M. | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
8/2/05 | | 6. AGE (In years
last birthday)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
5225 Pooks Hill Road | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
Director Retired | | 12b. KIND OF BUSINESS OR
INDUSTRY
IB Assoc. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before
admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
#308
5225 Pooks Hill Road | |
| 14. FATHER'S NAME
First Middle Last
Anton Korn | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Hanah Eberts | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
No -- | | 16b. SOCIAL SECURITY NO.
350-28-3005 | | 17. INFORMANT
Address Rockville, Md.
Pat Magruder 11905 Renwood Lane | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardio-respiratory failure</u>
<u>1749</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>metastatic pancreatic cancer</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>left cervical Breast</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>arteriosclerosis heart disease</u> | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>48 hrs</u>
<u>18 mos</u>
<u>3 yrs</u> | | |
| | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>1968</u> , 19 <u> </u> , to <u>1-15</u> , 19 <u>79</u> , that (1) (we) last
saw the deceased alive on <u>1-13</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>John M. Wyman M.D.</u> | | | | DEGREE
ATTENDING
PHYS. | | MED.
DIRECTOR <input checked="" type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>1/15/79</u> | |
| 22d. PHYSICIAN'S
NAME (Type)
<u>JOHN M. WYMAN M.D.</u> | | | | 22e. ADDRESS
<u>7801 North Ave Bethesda, Md 20814</u> | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>1/18/79</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Arlington National Cemetery Arlington, Virginia</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Arlington, Virginia</u> | | | |
| 24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home, Inc.</u> | | | | 25a. REC'D BY REGISTRAR
<u>JAN 15 1979</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Anthony McCready</u> | | | |
| 1331 Rockville Pike, Rockville, Maryland 20852 | | | | | | | | | |

8E050-02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02039
REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) VIRGIE E HILL | | | 2a. DATE OF DEATH
MONTH DAY YEAR January 17 1979 | | | 2b. HOUR 1:20 PM | | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH
MONTH DAY YEAR Aug. 3, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
MONTHS DAYS HOURS MIN 75 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. 13b. COUNTY Montg. 13c. CITY OR TOWN Silver Spring | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2315 Kansas Ave | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST DANIEL A. BROWN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST HARRIETT SNOWDEN | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO
217-30-0783 | |
| 17. INFORMANT
ADDRESS Myrtle Robbins (niece) Same as #13 | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction Inferior wall
410-
DUE TO, OR AS A CONSEQUENCE OF:
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF:
(c) 15 yrs | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Pleural Effusion | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTED TO CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR 19 68 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 68 to 17 Jan 19 79 , that (I) (we) last saw the deceased alive on 17 Jan 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Menton L. White MD | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
17 Jan 79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Menton L. WHITE, M.D. | | | 22e. ADDRESS
9911 Georgia Ave Silver Spring Md. | | | 22f. DATE REC'D. BY REGISTRAR
JAN 26 1979 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | | 23b. DATE
1-23-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Ash Memorial Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sandy Spring Montg. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME George R. Snowden | | | 24b. ADDRESS
246 N. Wash. St. Rockville, Md. | | | 25. DATE REC'D. BY REGISTRAR
JAN 26 1979 | | | | |

10-05030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02040
REG. NO. | |
|---|--|---|--|---|--|--|--|--|--|----------------------|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| | | JOHN HILTON | | | | 1 22 79 | | | | 7:55 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| male | | white | | NOV. 14 TH 1913 | | 65 | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| England | | USA | | | | Montgomery | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Silver Spring | | Holy Cross Hospital | | Bricklayer | | Building Contr. | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | Montgomery | | Sil. Spring | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 814 Silver Spring Avenue, | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | | | |
| (unknown) | | (unknown) | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | ADDRESS | | | | | |
| no | | none | | 377-38-9817 | | Edward J. Woodrow-step-son-Goodloe Rd. | | | | 11705 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 5715 | | Esophageal varices with hemorrhage | | | | | | 2 days | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) advanced portal cirrhosis | | | | | | 9 mo | | | |
| | | (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from | | 5/31 | | 19 77 | | to | | 1/22 | | 19 79 | |
| saw the deceased alive on | | 1/22 | | 19 79 | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | |
| George Senzstack M.D. | | | | | | 1-22-79 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| George Senzstack | | 9241 Columbia Blvd, Silver Spring Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY STATE | |
| Burial | | Jan. 25-79 | | Gate of Heaven | | Sil. Spring | | Montgomery | | Md. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Warner E. Pumphrey, Inc. | | JAN 29 1979 | | notary McCreedy | | | | | | | |
| 8434 Ga. Ave., S.S. Md. | | | | | | | | | | | |

10-05040

NAME: Baby Boy Hinton

DATE OF DEATH: January 24, 1979

PLACE OF DEATH: Montgomery County

SEE: #79-04684
February, 1979
Montgomery County

EXHIBIT 10715 E 10244 177

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-02041
REG. NO.

| | | | | | | | | | | | | |
|---|---------|--|---------------------------------|---|------------------|--|-------|---|-----------------------------------|--|--|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 1-1-79 | | | | | | | | | | 2b. HOUR <input checked="" type="checkbox"/> 8 AM |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2c. DATE PRONOUNCED DEAD 1-1-1979 | | | | | | | | | | 2d. HOUR <input checked="" type="checkbox"/> 11:53 AM |
| FIRST MIDDLE LAST | | 2e. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | 2f. HOUR |
| Sidney Elson Hobbs | | Montgomery MD. | | | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. | IF UNDER 24 HRS. | | | | | | | |
| Male | White | Nov. 8, 1915 | 63 | YRS. | MONTHS | DAYS | HOURS | MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | |
| Maryland | | USA | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | 12104 Viers Mill Rd. | | | | Painter | | | Construction | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | |
| Maryland | | Montgomery | | Silver Spring | | | | 12104 Viers Mill Rd. | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | |
| Samuel D. Hobbs | | | | Daisy V. Stevens | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | |
| NO | | | | none | | 577-16-0074 | | John McCann (son-in-law) 3605 Sandy Ct. Kens. Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Chronic Alcoholism | | | | | | | | | | | | |
| 303- DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | |
| Advanced Interstitial Pulmonary Process | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| | | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | |
| Richard L. Whelton | | | | Deputy | | | | 1-1-79 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | |
| Richard L. Whelton | | | | 5100 Baltimore Ave College Park | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | | |
| Burial | | 1-4-1979 | | Linthicum Chapel | | Clarksville | | | | Md. | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Warner E. Pumphrey, Inc. | | | | 8434 Georgia Ave. Silver Spring, Md. | | | | JAN 5 1979 | | Henry McCreedy | | |

BP

14050-82



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-02042 | |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | 7a. DATE OF DEATH | | MONTH DAY YEAR | | 7b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Annie H. Hoffman | | | | | | January 3, 1979 | | | | 6:45 P.M. | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 2, 1885 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5904 Welborn Drive | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Md. Montg. Bethesda | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5904 Welborn Dr. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John W. Hall | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sophia Haslip | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
457-84-3800 | | 17. INFORMANT
ADDRESS
John L. Hoffman Same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4140 Congestive Heart Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Arteriosclerotic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 week</u>
<u>5 years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>Pulmonary Fibrosis</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 20</u> , 19 <u>78</u> , to <u>Jan 3</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Dec. 31</u> , 19 <u>78</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>C. R. Gruver MD</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>1/4/79</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Clifton R. Gruver, M.D. | | | | | | 22e. ADDRESS
1145 19th St., N.W. Washington, D.C. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Jan. 6, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
National Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church, Va. | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A. | | | | | | 25a. DATE REC'D. BY REGISTRAR
Jan 8 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>notary McBrady</u> | | | |

72-02042

January 2, 1972

John L. Colman

Annals

22

1972

April

Washington

People

Northampton County

USA

Virginia

Bedford 2904 Albemarle Drive

Bedford

State of Virginia

Bedford

John L. Colman

John L. Colman

John L. Colman

John L. Colman

John L. Colman

John L. Colman

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John L. Colman

John L. Colman

John L. Colman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHM - 16 50M 7/77
(VR A 15 (4))

| FOR
STATE
REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 79-02043
REG. NO. | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Betty TENNISON Hoffman | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan 29 1979 | | 2b. HOUR
11:30 AM | |
| 3 SEX
Female | 4 RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
March 27, 1932 | | 6 AGE (IN YEARS LAST BIRTHDAY)
46
YRS. MONTHS DAYS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Education |
| 13a. STATE
Maryland | | 13b. COUNTY
Mont. | 13c. CITY OR TOWN
Germantown | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dan Carter Tennison | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Susie - Holland | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | 16b. SOCIAL SECURITY NO.
228-36-9354 | | 17. INFORMANT
ADDRESS
Walter D. Hoffman, Jr. Same as # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest
410- DUE TO, OR AS A CONSEQUENCE OF
(b) Myocardial Infarction
(c) Coronary Arteriosclerosis | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3 min
8 hrs
6 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Diabetes Mellitus Renal failure | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 4 19 72 to Jan 29 19 79, that (I) (we) lost
saw the deceased alive on Oct 14 19 78, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
James R. Moore Jr. | | DEGREE
MD | | 22c. DATE SIGNED
1-29-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James R. Moore Jr. | | 22e. ADDRESS
207 Brookes Ave Gaithersburg Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
SPECIFY
Removal-Burial | | 23b. DATE
Jan. 31, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Peninsula Mem. Park | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Newport News Warwick Va. | | | | | |
| 24. FUNERAL DIRECTOR
Francis H. Barber Laytonsville, Md. 20760 | | 25a. DATE REC'D BY REGISTRAR
JAN 31 1979 | | 25b. REGISTRAR'S SIGNATURE
Murray McCreedy | |

Dr. Sale cleared

70-05043

11-11-58

3 11-11-58
8 11-11-58
10 11-11-58

Diabetes Mellitus
Renal failure
Coronary Arteriosclerosis
Myocardial Infarction
Cardiomegaly Heart

11-11-58

1-24-59

and Brother for Confidentiality

James R. Moore Jr.

and Brother for Confidentiality

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02044 | |
|---|--|---|---|---|---|--|---|--|---|----------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1 DECEASED NAME
(TYPE OR PRINT)
John R. HOFFMAN | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 4 1979 | | | 2b. HOUR
3:07 PM | | | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 5 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Naval Medical Center | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U. S. Army | | 12b. KIND OF BUSINESS OR INDUSTRY
Military | | | | |
| 13a. STATE
Virginia | | | 13b. COUNTY
N/A | | 13c. CITY OR TOWN
Newport News | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
148 Merle Drive | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William N. Hoffman | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Myril Garlock | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
Korea | | 17. INFORMANT
ADDRESS
Denise Jean Hoffman Same as 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute perioperative myocardial infarction
410-
DUE TO, OR AS A CONSEQUENCE OF
(b) Atherosclerotic coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 3/4 hrs.
indeterminate | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION
4 Jan. 1979 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ischemic heart disease with evolving acute myocardial infarction | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 29 , 19 78 , to January 4 , 19 79 , that (I) (we) lost saw the deceased alive on January 4 , 19 79 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Horace R. Trumbull, M.D. | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Jan. 5, 1979 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Horace R. Trumbull, M. D. | | | | | | 22e. ADDRESS
National Naval Medical Center, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
1-7-79 | | 23c. NAME OF CEMETERY OR CREMATORY
VETERANS MEM CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hampton VA. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Capitol Funeral Service Falls Church, Va. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 9 1979 | | 25b. REGISTRAR'S SIGNATURE
Walter McBrady | | | |

BP

19-02044

Topic: E. H. HOTTEN
Date: January 2, 1977
Location: Washington, D.C.
Subject: National Naval Medical Center
Address: 1200 Harbor Drive
City: Annapolis, Maryland 21403
Phone: 410-293-1234
Fax: 410-293-1235
Responsible: Mr. H. Hottel
Contact: Mr. H. Hottel
Reference: 19-02044

Topic: E. H. HOTTEN
Date: January 2, 1977
Location: Washington, D.C.
Subject: National Naval Medical Center
Address: 1200 Harbor Drive
City: Annapolis, Maryland 21403
Phone: 410-293-1234
Fax: 410-293-1235
Responsible: Mr. H. Hottel
Contact: Mr. H. Hottel
Reference: 19-02044

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 79-02045 | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|--------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 20. DATE OF DEATH MONTH DAY YEAR 25 1979 | | | | 2b. HOUR 6 7 M | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST EVA T. HOLT | | | | 3. SEX Female | | | | 4. RACE White | | | | 5. DATE OF BIRTH MONTH DAY YEAR July 5 1883 | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS. | | | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | | 8. IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Wheaton | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT, IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | | | | | | | | | | | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | | | 13c. CITY OR TOWN Bethesda | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 5101-Ridgefield Road | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry O. Towles | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie E. ----- | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 579-60-2182 | | | | 17. INFORMANT Mr. Tom Ainora | | | | ADDRESS P.O. Box 1149 Washington, D.C. | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
410-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Arteriosclerosis, generalized</u>
(c) <u></u>
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr.
5 hr. | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 5/16 19 76 to 1/25 19 77, that (I) (we) last saw the deceased alive on 1/25 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. | | | | 22b. SIGNATURE Joseph J. Wallace MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/26/79 | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph J. Wallace MD | | | | 22e. ADDRESS 5272-River Rd., Bethesda, Maryland | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Jan. 30, 1979 | | | | 23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H. Inc. | | | | 11800-New Hampshire Ave. Silver Spring, Md. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 29 1979 | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

20-05042

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 79-02046
REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | FIRST MIDDLE LAST
HARRY MELVIN HORZ | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JANUARY 12, 1979 | | 2b. HOUR
4:35 p.m. | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
August 6, 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY)
51
YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | 7. IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Clinical Center, Bethesda, Md, NIH | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Police Officer | | 12b. KIND OF BUSINESS OR INDUSTRY
Law Enforcement | | | |
| 13a. STATE
Maryland | | | | 13b. CITY OR TOWN
Pasadena | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS
Rt. 3 box 67A, Pasadena, Md. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Herman Albert Horz, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Whitmore | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW 2 | | 17. INFORMANT
Mrs. Bessie Horz | | 17a. ADDRESS
Rt. 3, Box 67A
Pasadena, Md. 21122 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest
1729
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost
(b) Intracranial Bleeding
(c) Malignant Melanoma
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 8, 1979, to January 12, 1979, that (I) (we) lost saw the deceased alive on January 12, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
S. Selonick, M.D. | | | | DEGREE
M.D. | | | | 22c. DATE SIGNED
1/12/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. Selonick, M.D. | | | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH
CLINICAL CENTER, NIH, BETHESDA, MD. 20014 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/16/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie Anne Arundel, Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Mc Cully F.H. Mtn. & Tick Neck Rds., Pasadena, Md. 21122 | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1979 | | 25b. REGISTRAR'S SIGNATURE
F. H. Mtn. & Tick Neck Rds. | | | | | |

BP

12-05048

1/10/77
2122
The following information was received from the
1/10/77
2122
The following information was received from the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76
(VR A 15 (4))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-02047 |
|---|--|--|--|---|--|---|----------------------|--|--|-------------------|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Edward John HUGHSON, Jr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
January 21 1979 | | 2b. HOUR
03:28 AM | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
January 20 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Massachusetts | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Naval Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Air controller | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Navy | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE
Florida | | 13b. COUNTY
Duval | | 13c. CITY OR TOWN
Jacksonville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5717 Enchanted Drive | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Edward John Hughson Sr. | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Elizabeth Mary O'Connell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1943-1969 | | 17. INFORMANT
ADDRESS
Mildred Hughson See item 13 | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Squamous cell carcinoma pallate</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 29</u> , 19 <u>78</u> , to <u>Jan. 21</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Jan. 21</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>John H. Shelby, M.D.</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
Jan. 22, 1979 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN H. SHELBY, M.D. | | | | | 22e. ADDRESS
National Naval Medical Center, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
1/24/79 | | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ARLINGTON ARLINGTON VA. | | | | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT A. PUMPHREY FUNERAL HOME BETHESDA, MD | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 26 1979 | | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Robert A. Pumphrey</u> | | | | | |

MEDICAL CERTIFICATION

78-02047

Year 1943-1988 126 35 6234 Mildred Hughes 200 Item 13
Edward John Hughes Dr. Elizabeth Mary O'Connell
Florida Caval Jacksonville 2717 Eastgate Drive
Pellusda National Naval Medical Center U.S. Navy
in the North 118 USA X
Colonial January 20 1924
Lawrence John HUGHSON January 21 1920 03:28

Cardiomyopathy arrest
Sudden death cardiac collapse

x

Robert A. Murphy Funeral Home Bethesda, MD
ARLINGTON NATIONAL
ARLINGTON ARLINGTON VA
John R. Sherry, M.D.
National Naval Medical Center, Bethesda, MD
Jan. 21 1979
Jan. 21 1979
Jan. 21 1979
Jan. 21 1979
Jan. 21 1979

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02048
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
DAISY PAULINE HULL | | | 2a. DATE OF DEATH MONTH DAY YEAR
1 20 1979 | | 2b. HOUR
4:15 AM |
| 3. SEX
F | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR
1 2 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Potomac Valley Hsg Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY
None |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John Hull | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Annie P. Fraser | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-54-9188 | | 17. INFORMANT ADDRESS
Clark King 9863 Main St., Damascus, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Coronary Insufficiency</u>
4140
DUE TO OR AS A CONSEQUENCE OF <u>Arteriosclerosis of the Heart Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO OR AS A CONSEQUENCE OF <u>Generalized Arteriosclerosis</u>
(c) <u>1 DAY</u>
<u>10 YRS</u>
<u>20 YRS</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
<u>Congestive Heart Failure</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/5/79</u> 19 to <u>1/20/79</u> 19, that (I) (we) lost
saw the deceased alive on <u>11/5/79</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Henry C. Scruggs</u> DEGREE | | | | 22c. DATE SIGNED
<u>1/20/79</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Henry C. Scruggs MD.</u> | | | | 22e. ADDRESS
<u>5413 Cedarhane Bethesda Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1-24-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Rockville Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Montgomery Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
ROBERT A. PUMPHREY FUNERALHOMES P/A ROCKVILLE MD. | | | |
| 25a. DATE REC'D. BY REGISTRAR
FEB 14 1979 | | | | 25b. REGISTRAR'S SIGNATURE
<u>Henry C. Scruggs</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

13-05018

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 79-02049 | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Vincent W Hutton | | | | 2a. DATE OF DEATH MONTH DAY YEAR
Jan. 27 1979 | | | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR
Feb 1 1891 | | 6 AGE (IN YEARS LAST BIRTHDAY)
87 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Kiddwood Health Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Diamond Cab-Driver (Ret.) | | 12b. KIND OF BUSINESS OF INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Hutton | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
NOT AVAILABLE | | 13e. STREET ADDRESS
5721-Broadview Lane | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
034-07-0998 | | 16c. INFORMANT ADDRESS
George Hutton (son) 1304 Treacott Ave, Takoma Park | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Pneumonia left lower lobe - 2041
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic lymphocytic leukemia - 2041
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 19 1975 to Jan 27 1979, that (I) (we) lost saw the deceased alive on Jan 27 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death | | | | | | | |
| 22b. SIGNATURE
J. D. Hutton | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
27 Jan 79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. D. Hutton | | 22e. ADDRESS
7505 Democracy Blvd Bethesda | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Feb 1 - 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Congressional | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington D.C. | |
| 24. FUNERAL DIRECTOR OR OTHER PERSON IN CHARGE OF BURIAL
William Walters | | 25a. DATE REC'D. BY REGISTRAR
FEB 1 1979 | | 25b. REGISTRAR'S SIGNATURE
Henry McCreedy | | | |

72-02049

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 11/19/01 BY 1043

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02050

REG. NO.

| | | | | | | | |
|---|--|---|---|---|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE FIRST MIDDLE LAST)
Lelia Mae Isaacs | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 21 1979 | | 2b. HOUR
6:30 AM | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 14, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
La. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
Md. | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
521-18-3258 | |
| 17. INFORMANT
7401 Wisconsin Ave. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular accident.
436-
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebral arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)
Diffuse bilateral pneumonitis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
11/10/79 to 11/21/79 | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
P.M. 19 | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (the physician) attended the deceased from above, (II) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
George A. Gray, Jr., M.D. | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
George A. GRAY, JR., M.D. | | 22d. ADDRESS
2911 Arlington Road Bethesda, Md. | | 22e. DATE SIGNED
11/27/79 | | 22f. DATE SIGNED
11/27/79 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Feb. 1, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Rockville Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1979 | | 25b. REGISTRAR'S SIGNATURE
Kathleen McBratney | | | |

13-05020

CONFIDENTIAL

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 79-02051
REG. NO. | |
|--|--------------------|---|--|---|--|---|---|--|--|----------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Ada Jackson | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED Jan. 31 1979 | | 2b. HOUR 1:31 PM | | | |
| 3. SEX F | 4. RACE Blk | 5. DATE OF BIRTH
MONTH DAY YEAR Apr. 2, 1906 | | 6. AGE (IN YEARS)
DAY MONTHS YEARS 72 | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD Jan 31 1979 | | 2d. HOUR 1:31 PM | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Olney, Md. Montgomery County | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md. | | 13b. COUNTY Mont. | | 13c. CITY OR TOWN Olney | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1234 E. Randolph Rd. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George W. Smith | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LAURA V. JOHNSON | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
NAME ADDRESS
Clara Jackson 1234 E. Randolph Rd. Silver Spring Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Dis.
402-
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Hypertensive Heart Dis.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Yrs | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
George R. Snowden | | | | TITLE (SPECIFY)
M.D. | | MEDICAL EXAMINER | | DATE
Jan. 31/1979 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-7-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Good Hope Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Montg Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
George R. Snowden Rockville, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 8 1979 | | 25b. REGISTRAR'S SIGNATURE
Mary K. Brady | | | | | |

12050-27



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove copy to page 1. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-02052 | |
|---|--|---|--|--|--|---|--|--|--|---|--|
| 1- FOR
STATE
REGISTRAR | | 1 DECEASED NAME
(TYPE OR PRINT) <i>Elsie</i> | | | | 2a DATE OF DEATH
MONTH <i>JAN</i> DAY <i>9</i> YEAR <i>79</i> | | 2b HOUR
<i>1:37</i> P.M. | | | |
| 3 SEX
<i>Female</i> | | 4 RACE
<i>White</i> | | 5 DATE OF BIRTH
MONTH <i>Apr.</i> DAY <i>29</i> YEAR <i>1897</i> | | 6 AGE (IN YEARS LAST BIRTHDAY)
<i>82</i> YRS | | IF UNDER 1 YEAR
MONTHS <i></i> DAYS <i></i> | | IF UNDER 1 YRS
HOURS <i></i> MIN. <i></i> | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>New York</i> | | 7b CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
<i>MONTGOMERY</i> MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
<i>Rockville</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Hebrew Home of Greater Washington</i> | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Office Employee</i> | | 12b KIND OF BUSINESS OR INDUSTRY
<i>Dept of HEW</i> | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE <i>D.C.</i> 13b COUNTY <i>-----</i> 13c CITY OR TOWN <i>Washington</i> | | | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
<i>2900 Erie Street S.E.</i> | | | | | |
| 14 FATHER'S NAME
FIRST <i>Edward</i> MIDDLE <i>Aaron</i> LAST <i>Schoenberger</i> | | | | 15 MOTHER'S MAIDEN NAME
FIRST <i>Gussie</i> MIDDLE <i>-----</i> LAST <i>Spitzer</i> | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <i>No</i> | | | | 16b SOCIAL SECURITY NO.
<i>084-05-7546</i> | | 17 INFORMANT
ADDRESS <i>N.Y.</i>
<i>Ruth Gross; 465 E. Lincoln Ave. Mt. Vernon</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>
<i>4140</i>
DUE TO, OR AS A CONSEQUENCE OF,
(b) <i>Arteriosclerotic heart disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>generalized arteriosclerosis</i> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>3 days</i>
<i>5 yrs</i>
<i>5 yrs.</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
<i>organic brain syndrome, uremia, anemia, hypertension, arteriosclerosis obliterans</i> | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from <i>10/3</i> , 19 <i>73</i> , to <i>1/9</i> , 19 <i>79</i> , that (I) (we) lost
saw the deceased alive on <i>1/9</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Maurice Franks</i> | | | | DEGREE
<i>MD</i> | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>1/9/79</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Maurice Franks, MD</i> | | | | 22e. ADDRESS
<i>6121 Montrose Rd, Rockville, MD 20852</i> | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY) <i>Burial</i> | | | | 23b. DATE
<i>1-10-79</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>New Mt. Carmel Cem.</i> | | 23d. LOCATION
CITY OR TOWN <i>Brooklyn, New York</i> COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME <i>Danzansky-Goldberg Chapels; 1170 Rockville Pike</i> | | | | ADDRESS <i>Rockville, Md.</i> | | 25a. DATE RECEIVED BY REGISTRAR
<i>JAN 12 1979</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

18-05025

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02053 | |
|---|--|--|----------------------------|---|---|--|----------------|---|----------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) ANNA G JARBOE | | | | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | | |
| | | | | | JAN 2 79 | | 5:20 | | A.M. | | |
| 3. SEX
FEMALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 09 98 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash DC | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SLIGO GARDENS NURSING HOME | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
St Mary | | 13c. CITY OR TOWN
MECHANICS VILL | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
Box 399 RT 1 | | | |
| 14. FATHER'S NAME
FIRST George MIDDLE Lee LAST Gibbs | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE Lusby LAST Matteer Lusby | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
578-05-8153-D | | 17. INFORMANT ADDRESS
SLIGO GARDENS 7525 CARROLL AVE TAK. PARK | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Resp and Cardiac arrest
436-
DUE TO, OR AS A CONSEQUENCE OF
(b) Massive EVA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(c)
DUE TO, OR AS A CONSEQUENCE OF
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Malnutrition - pt not able to eat. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/25/78 , 19____, to 1/2 , 19 79 , that (I) (we) lost saw the deceased alive on 12/30/78 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/2/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SMITH HS M.D. | | | | | | 22e. ADDRESS
8323 HADDON DR. TAKOMA PK. M.D. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
1/4/79 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Johns Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hollywood St. Mary's Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
W. Clarke Mattingley Leonardtown, Md. | | | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
JAN 8 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

73-05023

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02054
REG. NO. | | | | | |
|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR P M | |
| 1. DECEASED NAME FIRST MIDDLE LAST
Amy Wilfreda Jester | | | | January 25, 1979 | | | | 4:15 P M | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
November 11, 1914 | | 6 AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NIH Clinical Center, Bethesda, Md. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
WIC | | 13c. CITY OR TOWN
Jesterville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Wilfred R. Jester | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Anna Renick | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
220-09-1058 | | 17. INFORMANT ADDRESS
Mr. Wilfred R. Jester Salisbury, Md. 21801 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic Failure
1715
DUE TO, OR AS A CONSEQUENCE OF
b) Renal Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
c) Malignant Fibrous Histiocytoma | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 Mo
3 Days
6 Months | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION
08/07/78 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Intra Abdominal Tumor | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (x) this hospital attended the deceased from January 11, 1979, to January 25, 1979, that (xx) (we) lost saw the deceased alive on January 25, 1979, and that in (xx) (our) opinion death occurred on the date and hour and from the causes stated above, (xx) (we) did (xx) (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE
[Signature] | | | | 22c. DATE SIGNED
1/25/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STRAUSSER, JOHN | | | | 22e. ADDRESS
9000 NIH, Clinical Center, Bethesda, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/27/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Grove Cem | | 23d. LOCATION
CITY OR TOWN COUNTY
Jesterville, MD | | 23e. ZIP CODE
20014 | |
| 24 FUNERAL DIRECTOR
NAME
[Signature] | | | | ADDRESS
BN 210, MD | | 25a. DATE REC'D BY REGISTRAR
JAN 31 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

MEDICAL CERTIFICATION

42020-01

101 Long Street
Mr. Wilfred R. Jensen, Secretary, Inc. 11001

January 11 1972
January 12 1972
January 13 1972

W.H. Clinical Center

10001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02055
REG. NO. | | | |
|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | 2a DATE OF DEATH MONTH DAY YEAR | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Basil E. Johnson | | | | 2b HOUR
11:40 PM | | | |
| 3 SEX
male | | 4 RACE
white | | 5 DATE OF BIRTH MONTH DAY YEAR
Oct. 13, 1895 | | 6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
83 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10 CITY OR TOWN OF DEATH
Wheaton | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
University Nursing Home | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
carpenter | | 12b KIND OF BUSINESS OR INDUSTRY
building | |
| USUAL RESIDENCE (# NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13a STATE
Maryland | | 13b COUNTY
Howard | | 13c CITY OR TOWN
Columbia | | 13e STREET ADDRESS
6609 Rt# 29 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Basil Johnson | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Letitia Manakee | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
yes | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
212 14 1321 | | 17 INFORMANT ADDRESS
Florence Johnson 6609 Rt# 29 Columbia, Md. 21046 | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardio-Respiratory Arrest
436- DUE TO, OR AS A CONSEQUENCE OF
(b) stroke - CVA - many years duration
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 10-14 , 19 75 , to 1-17 , 19 79 , that (I) (we) lost saw the deceased alive on 1-15 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not see the body after death. | | | | | | | |
| 22b SIGNATURE
Myron A. Leubow | | | | DEGREE
ATTENDING PHYSICIAN | | 22c DATE SIGNED
1-17-79 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e ADDRESS | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
burial | | 23b DATE
1/20/79 | | 23c NAME OF CEMETERY OR CREMATORY
St. Marks Cem. | | 23d LOCATION CITY OR TOWN COUNTY STATE
Highland, Howard, Maryland | |
| 24 FUNERAL DIRECTOR NAME
SLACK Funeral Home, Ellicott City, Maryland 21043 | | | | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE
JAN 22 1979 | | | |

22050-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1- STATE REGISTRAR | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02056
REG. NO. | | | |
|---|--|--|--|--|--|---|--|--|--|-------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)
F. CARL JOYCE
FREDERICK C. JOYCE | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-20-79 | | | | 2b. HOUR
5:42 AM | | | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
MARCH 30, 1898 | | 6 AGE (IN YEARS LAST BIRTHDAY)
80 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WEST VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SERVICE REPAIRMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
BURROUGHS CORP. | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2019 OSBORN DRIVE | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN JOYCE | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CORA ADAMS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
171-07-9189 | | 17. INFORMANT
R. LAVURN JOYCE | | ADDRESS
SAME AS 13 | | WIFE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
5715 IMMEDIATE CAUSE (a) hepatic cirrhosis
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 mo | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 2b, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-19-79 to 1-20-79, that (I) saw the deceased alive on 1-19-79, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
George Sengstack | | | | DEGREE
M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-20-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
George Sengstack | | | | 22e. ADDRESS
Silver Spring, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
1/22/79 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
CITY OR TOWN COUNTY MD.
SILVER SPRING MONT | | | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 22 1979 | | 25b. REGISTRAR'S SIGNATURE
R. Lavurn Joyce | | | | | |
| 500 UNIV. BLVD. W. SILVER SPRING, MD. 20901 | | | | | | | | | | | |

10-05026

CAR



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02057

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
ALICE C KAISER | | | 2a. DATE OF DEATH MONTH DAY YEAR
1-25-79 | | 2b. HOUR
11:25 AM |
| 3 SEX
Female | 4 RACE
Cauc | 5. DATE OF BIRTH MONTH DAY YEAR
4 15 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN
79 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Nebraska | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bethesda Health Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Elgin Watch |
| 13a. STATE
Md. | | | 13b. COUNTY
P.G. | 13c. CITY OR TOWN
Clinton | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John E. Anderson | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Antonia E. Krochewski | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
508-22-0243 | | 17. INFORMANT ADDRESS
Virginia I. Foltz same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardio respiratory arrest
0091
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebral Artery Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Generalized arteriosclerosis, atherosclerosis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/2/79 , 19 79 , to 1/25/79 , 19 79 , that (I) (we) last saw the deceased alive on 1/19/79 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
W. Camina | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Wilhelmina Camina | | 22e. ADDRESS
4701 Randolph Road
Rockville Md 20852 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/29/79 | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Mem. Park Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Lincoln Nebraska |
| 24. FUNERAL DIRECTOR NAME
See Funeral Home Inc.
6633 Old Alex. Ferry Rd. Clinton, Maryland | | | 25a. DATE REC'D. BY REGISTRAR
JAN 30 1979 | | 25b. REGISTRAR'S SIGNATURE
Henry McHenry |

MEDICAL CERTIFICATION

1251

653 Old Alex, Perry St., Clinton, Maryland JAN 30 1979

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02058

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Edward Anthony Kane | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 04, 1979 | | 2b. HOUR
1:20 A M | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 14, 1920 | | 6 AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. Y. | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
The Clinical Center, NIH Bethesda Md. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Attorney | | 12b. KIND OF BUSINESS OR INDUSTRY
Private practice | |
| 13a. STATE
New York | | 13b. COUNTY
Westchester | | 13c. CITY OR TOWN
Hartsdale | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Gaspere Bisacane | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lucy Biscano | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
093-09-8473 | |
| 17. INFORMANT
ADDRESS
Hartsdale, New York 10530 | | 17. INFORMANT
Mrs. Leone Kane, 500 High Point Drive | | 17. INFORMANT
Mrs. Leone Kane, 500 High Point Drive | | 17. INFORMANT
Mrs. Leone Kane, 500 High Point Drive | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4149
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) DUE TO, OR AS A CONSEQUENCE OF
AORTIC VALVE REPLACEMENT
(c) DUE TO, OR AS A CONSEQUENCE OF
CORONARY ARTERY DISEASE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 HOURS
12 HOURS
YEARS | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1) OR PART 2 | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 17, 1978, to January 04, 1979, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on January 04, 1979, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. | | 22b. SIGNATURE
R.E. Michalik M.D. | | 22c. DATE SIGNED
1-4-79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R.E. Michalik M.D. | | 22e. ADDRESS
of Health, Bethesda, Md. 20014
The Clinical Center, National Institutes | | 22f. ADDRESS
of Health, Bethesda, Md. 20014
The Clinical Center, National Institutes | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
Jan. 4, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Wellwood | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Farmingdale N. Y. | |
| 24 FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Chapel Inc. Rockville, Md. | | 24b. DATE REC'D. BY REGISTRAR
JAN 11 1979 | | 24c. REGISTRAR'S SIGNATURE
Morty McElroy | | | |

72-05028

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02059
REG. NO. | |
|---|---|---|--|--|---|
| 1. FOR STATE REGISTRAR | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Joseph Gabriel Kane | | | 2a. DATE OF DEATH MONTH DAY YEAR
Jan 22 1979 | | 2b. HOUR
M |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH MONTH DAY YEAR
3 17 19 | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | 12a. USUAL OCCUPATION (IF DECEASED WAS NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Medical Executive | 12b. KIND OF BUSINESS OR INDUSTRY
Baker | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE 13c. COUNTY 13d. CITY OR TOWN
Maryland Montgomery Silver Spring | | | 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13f. STREET ADDRESS
2100 Washington Avenue. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John J. Kane | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE
Bridget McGlen | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
WW II | 17. INFORMANT ADDRESS
McLaughlin Funeral Home, Wilkesboro, Pa. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u>
4254
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Primary Cardiomyopathy</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr.
8 yrs. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Diabetes Mellitus</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 1971</u> , to <u>Dec 26 1978</u> , that (I) (we) last saw the deceased alive on <u>Dec 26 1978</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE DEGREE
<u>Keith M. Lindgren M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/23/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Keith M. Lindgren, MD | | 22e. ADDRESS
7600 Carroll Ave Takoma Park, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1-25-79 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Marys Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Montgomery Pa. | | | | | |
| 24. FUNERAL HOME, ETC.
Wanner E. Pumphrey, Inc.
8434 Ga. Ave., S.S. Md. | | 25a. FILE REC'D. BY REGISTRAR
JAN 26 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>George H. Brady</u> | |

72-03028

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-02060

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|-------------------------|--|---|--|-------------------|--|--|--|------------------|--|---|--|----------|--|---|--|----------------------------|--|---------|--|--|--|
| 1- STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | | | | | | | | | 7b. HOUR | | | | | | | | | | | |
| DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | ESTIMATED | | MONTH | | DAY | | YEAR | | HOUR | | | | | | | |
| STANLEY | | | | | | KAPLAN | | | | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR | | | | | | | | | |
| MALE | | WHITE | | July 2 1938 | | 38 YRS. | | MONTHS | | DAYS | | HOURS | | MIN | | Jan 14 1979 | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| New York | | | | USA | | | | | | | | Montgomery MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Bethesda | | | | Suburban Hosp | | | | | | | | Elec. Engineer | | | | Elec. Eng. Co. | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | | | | | |
| Va | | | | Fairfax | | | | Falls Church | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 1931 Kennedy Dr. | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | | | | | FIRST MIDDLE LAST | | | | | | | | | | | | | | | |
| Max Kaplan | | | | | | | | Jean Rosenberg | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | Florida | | | |
| No | | | | | | | | 053-30-2820 | | | | Jean Kaplan 2385 N.E. 173rd St. N. Miami Bea | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute Myocardial Infarction | | | | | | | | | | | | | | | | | | | | | | | |
| 4391 | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | | | |
| None | | | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| | | | | | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | |
| | | | | | | | | P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | | | |
| | | | | | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | | | | | |
| John S. Rogers | | | | | | | | M.D. Dep | | | | Jan 14 1979 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | | ADDRESS | | | | | | | | | | | | | | | |
| | | | | | | | | 1919 Seminary Rd. Silver Spring, Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | COUNTY STATE | | | | | | | |
| Cremation | | | | 1-16-79 | | | | Slade Crematory | | | | Hialeah, | | | | Florida | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | | | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Joseph Gawler & Sons 5150 Wisc. Ave. Wash. D.C. | | | | | | | | | | | | | | | | JAN 18 1979 | | Anthony McCurdy | | | | | |

12-05080

WATER

WATER

2 -

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02061

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|-----------------------------------|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Norman Milton KARNs, JR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 22 1979 | | | 2b. HOUR
7:18A | | | | | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 29, 1939 | | 6. AGE (IN YEARS LAST BIRTHDAY)
39 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
California | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Naval Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U. S. Navy | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Virginia | | | | | | 13b. COUNTY
Alexandria | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5021 Seminary Road, Apt. 714 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Norman Milton Karns, Sr. | | | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Verginia Trevy | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1961-79 | | 17 INFORMANT ADDRESS
NORMAN MILTON KARNs SR.
Navy Records - SEE #13-E | | | | | |

| | | | |
|---|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>pneumocystosis</u>
2019
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>HODGKINS DISEASE STAGE III</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
|---|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 10:

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>12 Jan.</u> , 19 <u>79</u> , to <u>22 Jan.</u> , 19 <u>79</u> , that (b) (we) lost
saw the deceased alive on <u>22 Jan.</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
(c) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Norman</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Jan. 23, 1979 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>W. J. CURRAN</u> | | | | 22e. ADDRESS
National Naval Medical Center, Bethesda, Md. | | | |

| | | | | | | | |
|--|--|---------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
Jan 23, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee Funeral Home | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington D.C. | |
| 24. FUNERAL DIRECTOR
Marshal Funeral Home Washington, D. C. | | | | DATE REC'D. BY REGISTRAR SIGNATURE
JAN 26 1979 <u>Barney McCready</u> | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

79-02061

Male
Denonian
Sept. 29, 1932
29
January 22 1972 7:16
Northern Hilton KAHNS, JR.
California
USA
National Naval Medical Center
U. S. Navy
Virginia
Alexandria
x
5021 Seminary Road, Apt. 714
Tracy
Virginia
Northern Hilton KAHNS, JR.
Yes
1961-79
220 SE 26th
Navy Records
29

Funeral Home Washington, D. C.
Funeral Home Washington, D. C.
Washington
D. C.
22 Jan. 79
12 Jan. 79
22 Jan. 79
Jan. 22, 1979
National Naval Medical Center, Bethesda, Md.
x

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02062
REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Peter E Kehoe | | | 2a. DATE OF DEATH
MONTH DAY YEAR
01 19 79 | | | 2b. HOUR
3:15 a.m. | | | |
| 3. SEX
M | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 04 90 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MANAGER | | 12b. KIND OF BUSINESS OR INDUSTRY
CREDIT UNION | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
11508 MAPLE VIEW DRIVE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PATRICK KEHOE | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
KATHERINE WHELAN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
335-16-0991 | | 17. INFORMANT
RITA E. KEHOE | | ADDRESS
SAME AS 13 | | WIFE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Shock</u>
0384
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Gram Negative Septicemia</u>
(c) <u>Gram Negative Septicemia</u>
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Under 24 hrs</u>
<u>Under 24 hrs</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-3</u> , 19 <u>78</u> , to <u>1-19</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1-19</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Morris Perry</u> | | | | DEGREE
<u>M.D.</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>1-19-79</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MORRIS PERRY | | | | 22e. ADDRESS
SILVER SPRING, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
1/22/79 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | | |
| 24. FUNERAL DIRECTOR
FRANCIS J. COLLINS
500 th UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 22 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Robert A. Brady</u> | | | |

12-05005



1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02063

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) George Washington Kelley, Jr. | | | 2a. DATE OF DEATH
MONTH January DAY 16 YEAR 1979 | | | 2b. HOUR
6:00P M | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH Oct. DAY 25 YEAR 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 | | 7. IF UNDER 1 YEAR
MONTHS YRS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1110 Fidler Lane | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Scientific Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET ADDRESS
1110 Fidler Lane | |
| 14. FATHER'S NAME
FIRST George MIDDLE Washington LAST Kelley Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST Caroline MIDDLE Spreilman LAST | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
579 58 6796 | | 17. INFORMANT
ADDRESS
George R. Kelley | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
1890 IMMEDIATE CAUSE (a) Carcinoma of left Kidney
DUE TO, OR AS A CONSEQUENCE OF (b) 2 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Congestive Heart Failure | | | | | | | | | | |
| 19a. DATE OF OPERATION
7-23-78 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH 19 DAY 19 YEAR 1979 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET 6719 Wilson Lane CITY OR TOWN Bethesda COUNTY Maryland STATE Pa. | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-23-78 , 19 78 , to 1-16-79 , 19 79 , that (I) (we) lost saw the deceased alive on 1-8-79 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Stephen Dejter, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/17/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephen Dejter, M.D. | | | | 22e. ADDRESS
6719 Wilson Lane Bethesda Maryland | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
1/19/79 | | 23c. NAME OF CEMETERY OR CREMATORY
West Laurel Hills | | 23d. LOCATION
CITY OR TOWN Philadelphia, Pa. COUNTY Pa. STATE | | | |
| 24. FUNERAL DIRECTOR
NAME ROBERT A. PUMPHREY
HOMES, P.A. BETHESDA, MARYLAND | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 23 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12-05083

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02064
REG. NO. | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|----------|---------------------|-----------------------------------|-------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | 2b. HOUR | | | | |
| Helen L. LOUISE Kelley | | | | | | 1-18-79 | | | 5 35 | | A.M. | | | | |
| 3 SEX | | | 4 RACE | | | 5. DATE OF BIRTH | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | 7 IF UNDER 1 YEAR | | 8 IF UNDER 24 HRS | |
| FEMALE | | | WHITE | | | OCT 28, 1906 | | | 72 | | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | |
| MARYLAND | | | U.S.A. | | | | | | Montgomery | | | | C & P | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| SILVER SPRING | | | Holy Cross Hospital | | | BUSINESS OFFICE WORK | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 14 INSIDE CITY LIMITS? | | | 15a. STREET ADDRESS | | | |
| MARYLAND | | | MONTGOMERY | | | SILVER SPRING | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 302 MANSFIELD ROAD | | | |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | | | | | | | | | | | |
| MICHAEL C. KELLEY | | | NORA BRODERICK | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17 INFORMANT | | | ADDRESS | | | | | | |
| NO | | | 577-01-0634 | | | THERESA C. McMAHON | | | SAME AS 13 | | | SISTER | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC CARCINOMA | | | | | | | | | | | | | | | |
| 1749 DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA RIGHT BREAST | | | | | | | | | | 10 years | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | |
| | | | P.M. 19 | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/14/78 to 1/18/79, that (I) (we) lost saw the deceased alive on 1/17/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED | | | | | | | | | |
| Hubert J. Alpert, M.D. | | | | | | 1/18/79 | | | | | | | | | |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22b. ADDRESS | | | | | | | | | | | | |
| HUBERT J. ALPERT, M.D. | | | 8630 FENDON ST SILVER SPRING, MD. 20910 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | | | | |
| BURIAL | | | 1/22/79 | | | ST. JOHN'S CEMETERY | | | FOREST GLEN MONT MD. | | | | | | |
| 24 FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| FRANCIS J. COLLINS | | | JAN 19 1979 | | | Rickey McCreedy | | | | | | | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | | | | | | | |

12-05064

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | 79-02065 |
|--|---------------------|--|---|---|--|---|--|---|---|---|--|----------|
| FOR STATE REGISTRAR | | | | | | | | | | | | REG. NO. |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Francis Kernan Kelly</i> | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR HOUR
<i>Jan 9 1979</i> | | | | | | |
| 3. SEX
<i>M</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>July 24 20 58</i> | 6. AGE (IN YEARS)
LAST BIRTHDAY
<i>58</i> | IF UNDER 1 YR.
MONTHS DAYS
<i>0 0</i> | IF UNDER 24 HRS.
HOURS MIN.
<i>0 0</i> | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
<i>Jan 9 1979</i> | | | 7d. HOUR
<i>PM</i> | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>New York</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Si-L-Spg</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>1832 Winding Way Lane</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR INDUSTRY)
<i>Salesman</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Furniture Store</i> | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | |
| 13a. STATE
<i>Md.</i> | | 13b. COUNTY
<i>Mont.</i> | | 13c. CITY OR TOWN
<i>Si-L-Spg</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>1832 Winding Way Lane</i> | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Francis P. Kelly</i> | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>M. Agnes Kernan</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
<i>Yes</i> | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>WWII 091/16/8308</i> | | 17. INFORMANT
<i>Dorothy A. Kelly</i> | | 17b. ADDRESS
<i>1632 Winding Way Lane Wheaton, Md 20902</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Gunshot Wound at chest</i>
9554
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
<i>None</i> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>None</i> | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
<i>1100 P.M. 1 9 79 Shot self</i> | | | | 21b. TIME OF INJURY
HOUR (A.M.) MONTH DAY YEAR
<i>1100 P.M. 1 9 79</i> | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
<i>Home</i> | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>Winding Way Lane, Si-L-Spg, Mont. Md.</i> | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John Rogers</i> | | | | TITLE (SPECIFY)
<i>M.D. Dep</i> | | | | DATE SIGNED
<i>Jan 9 1979</i> | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
<i>John Rogers</i> | | | | ADDRESS
<i>1919 Seminary Rd. S.S.Md.</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Cremation</i> | | | | 23b. DATE
<i>1/12 /79</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Ft. Lincoln Crematory</i> | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Brentwood PG Md.</i> | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Hines/Rinaldi F.H.</i> | | | | | | ADDRESS
<i>11800 N.H. Ave. Silver Spring, Md.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 31 1979</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Anthony McCready</i> | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

13-05082

1919 Cemetery Rd. S. S. N.Y.

John Rogers

Creation 1/ 179 Ft. Lincoln Cemetery Grounds N.Y.

1919 Cemetery Rd. S. S. N.Y.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02066

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Aisha Khan | | January 10, 1979 | | 11:15AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| Female | White | Feb. 18 1901 | 77 YRS. | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| India | Pakistan | | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Olney | Montgomery General Hospital | Housewife | none | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| Maryland | | Mont. | Wheaton | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 12014 Bluehill Road |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| U/K | | U/K | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| no | | None | Waldolf, Md.
Sone Saleem Khan -84 Forrest Glenn Ct. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u>
<u>5728</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
<u>SEPTICEMIA</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 week</u> |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 1, 1979</u> to <u>January 10, 1979</u> , that (I) (we) last saw the deceased alive on <u>January 10, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>Barry Hecht</u>
DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>Jan. 10, 1979</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Barry Hecht, M. D. | | 22e. ADDRESS
<u>10620 Georgia Ave.</u>
<u>Silver Spring, MD 20902</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| Burial | 1-11-79 | Islamic Gardens Cem. | Falls Church, Va. | | |
| 24. FUNERAL DIRECTOR
NAME
<u>John F. DeVol</u> | | 24b. ADDRESS
<u>DeVol Funeral Home</u>
<u>Washington, D.C.</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>JAN 16 1979</u> | 25b. REGISTRAR'S SIGNATURE
<u>Barry Hecht</u> |

70-02066



Oct. 18 1961

White

Wanda

Pakistan

India

x

born

Hunnsville

1901, Bluebird Road

Wharton

Maryland, Mont.

x

UK

UK

Waldell, W.

Some Palace Khan - 64 Terrace Glenn Co.

None

no

no

Felix Church, Va.

Infant's Garden Cem.

1-12-70

Baylor

Loyal Funeral Home

Washington, D.C.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02067
REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 3. SEX | | 4. RACE | |
| Farida | | Female | | Caucasian | |
| 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | |
| Aug. 10, 1924 | | 54 | | Iraq | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | |
| | | Montgomery County | | Bethesda | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 5225 Pooks Hill Road | | Homemaker | | Home | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Maryland | | Montgomery | | Bethesda | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | |
| Ali | | Zakia | | no | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH | |
| 577-72-2699 | | Sameera Hartsough 4450 S. Park Ave | | Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) carcinoma of breast
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
CONDITIONS, IF ANY, WHICH
GAVE RISE TO IMMEDIATE
CAUSE (a), STATING THE
UNDERLYING CAUSE LAST | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from 12/12, 1978, to 1/2/79, that (1) (we) last saw the deceased alive on 12/21, 1978, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death | | 22b. SIGNATURE
James H. Brodsky, M.D. | | 22c. DATE SIGNED
1-2-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | |
| James H. Brodsky, M.D. | | 4701 Willard Ave. Chevy Chase, MD | | Cremation | |
| 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 1/3/79 | | Metropolitan Crem. | | Alexandria, Virginia | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | JAN 8 1979 | | | |

1. FOR STATE REGISTRAR

2. DATE OF DEATH

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS LAST BIRTHDAY)

7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

14. FATHER'S NAME

15. MOTHER'S MAIDEN NAME

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (1) this hospital attended the deceased from 12/12, 1978, to 1/2/79, that (1) (we) last saw the deceased alive on 12/21, 1978, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death

22b. SIGNATURE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR
NAME

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

79-02087

January 2, 1979

John

Patricia

John

Patricia

John

24

Montgomery County

Montgomery County

John

Montgomery County

Montgomery County

John

Montgomery County

Montgomery County

John

Montgomery County

John

Patricia

John

Montgomery County

John

Montgomery County

John

Patricia

John

Montgomery County

Montgomery County

Montgomery County

Montgomery County

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
|--|--|-------------|--|--|---|---|--|---|--|---|--|--------------------------------------|--|-----------|--|
| 1. FOR STATE REGISTRAR | | | | | 79-02069
79-02 | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | 2a. DATE KNOWN OF DEATH | | | | | 2b. HOUR | | | | | |
| FIRST MIDDLE LAST
Billy Joe King | | | | | DATE KNOWN OF DEATH ESTIMATED
1 17 19 79 | | | | | HOUR
4:10 P.M. | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | | White | | Oct. 15, 1957 | | 21 YRS. | | MONTHS | | DAYS | | 1 17 19 79 | | 4:10 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | | | U.S.A. | | | | | | | | Montgomery County, MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Olney | | | | Montgomery General Hospital | | | | Construction work | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | |
| Md. | | Montgomery | | Gaithersburg | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 11 Chestnut St. - Apt. 2 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | | |
| John King | | | | | Lorena Evans | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ADDRESS | | | | | |
| No | | | | | 215-72-7502 | | | | | 8 N. Summit Dr.
Gaithersburg, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cranio-Cerebral Injuries</u>
8150
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | 21b. TIME OF INJURY
HOUR AM MONTH DAY YEAR
3:20 P.M. 1 17 19 79 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| | | | | | | | | | | Driver of auto/fixed object impact | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | street | | | | | Sundown Rd. Montgomery, Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | TITLE (SPECIFY) | | | | | DATE SIGNED | | | | | |
| Margarita A. Korell, M.D. | | | | | Assistant | | | | | 1/18/79 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | ADDRESS | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | | | 111 Penn Street | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | |
| Burial | | | | | Jan. 22, '79 | | | | | Parklawn Cemetery | | | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| R. Gartner-Sandison | | | | | 316 E. Diamond Ave., Gaithersburg, Md. 20760 | | | | | JAN 23 1979 | | | | | |

13-05008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examiner's certificate must be attached.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1- FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 79-02069 | |
| Hildegard | | A. | | KINSINGER | | JANUARY 7 1979 | | 430 P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Female | | White | | April 23 07 | | 71 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. IF UNDER 24 HRS. | |
| Nebraska | | USA | | | | Montgomery | | MONTHS DAYS HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. PLACE OF DEATH | |
| Olney | | Montgomery Gen. Hospital | | | | Teacher (Ret.) | | Montgomery, Md. | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md. | | Mont. | | S.S. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3409 Parker Creek Lane | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | | | |
| Conrad Baumgartner | | | | | Mary Stroy | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| No | | 220 32 5704 | | Donald Kinsinger (Husband) | | Same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC BREAST CARCINOMA | | | | | | | | 2 YEARS | |
| 1749 DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) | | | | | | | | | |
| MALIGNANT PLEURAL EFFUSION | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| JANUARY 6, 1979 | | CHEST TUBE : PLEURAL EFFUSION | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from JANUARY 6, 1979, to JANUARY 7, 1979, that (I) have lost saw the deceased alive on JANUARY 7, 1979, and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was not did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| Barry Hecht | | MD | | | | | | 1/7/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| BARRY HECHT | | | | 10620 GEORGIA AVENUE SILVER SPRING | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY STATE | |
| Burial | | 1/10/79 | | Parklawn Cemetery | | Rockville | | Montgomery, Md. | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Hines/Rinaldi F.H. 11800 N.H. Ave. Silver Spring, Md. | | | | JAN 11 1979 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | |
|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. 79-02070 | |
| 1 DECEASED NAME
(TYPE OR PRINT) <u>MOLLIE</u> | | 2a. DATE OF DEATH MONTH <u>1</u> DAY <u>4</u> YEAR <u>79</u> | |
| 3 SEX <u>FEMALE</u> | | 2b. HOUR <u>12:25 PM</u> | |
| 4 RACE <u>CAUC</u> | | 5. DATE OF BIRTH MONTH <u>9</u> DAY <u>7</u> YEAR <u>98</u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Baltimore, Md</u> | | 6 AGE (IN YEARS LAST BIRTHDAY) <u>80</u> YRS | |
| 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10 CITY OR TOWN OF DEATH <u>Gaithersburg, Md</u> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery Co, MD.</u> | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SHARON NURSING Home</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Sales Clerk</u> | |
| 12b. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u> | | | |
| 13a. STATE <u>Md.</u> | | 13b. COUNTY <u>MONTG</u> | |
| 13c. CITY OR TOWN <u>KENSINGTON</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS <u>10920 Connecticut Ave.</u> | | | |
| 14 FATHER'S NAME FIRST <u>Charles</u> MIDDLE <u>-</u> LAST <u>Cohen</u> | | 15 MOTHER'S MAIDEN NAME FIRST <u>Toby</u> MIDDLE <u>(UNKNOWN)</u> LAST <u>(UNKNOWN)</u> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> | | 16b. SOCIAL SECURITY NO. <u>579-50-8056</u> | |
| 17 INFORMANT <u>Paul Weintraub; 3113 Beckenham Ct., SSpg, Md</u> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u>
<u>1539</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CANCER OF COLON</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21g. LOCATION CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>May 4</u> , 19 <u>78</u> , to <u>Jan 4</u> , 19 <u>79</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>Jan. 4</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE <u>Pedro Maitas</u> | | 22c. DATE SIGNED <u>Jan 4 79</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PEDRO I. MAITAS</u> | | 22e. ADDRESS <u>1811 Prince Philip Drive Olney Md 20832</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>1-7-79</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Beth Shalom Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Capital Heights, Maryland</u> | |
| 24 FUNERAL DIRECTOR NAME <u>Danzansky-Goldberg Chapels; 1170 Rockville Pike</u> | | 25a. DATE REC'D BY REGISTRAR <u>Jan 11 1979</u> REGISTRAR'S SIGNATURE <u>Cherry</u> | |

18-05000

(unpublished)

18-05000

18-05000

18-05000

18-05000

18-05000

18-05000

18-05000

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02071
REG. NO.1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|--|--|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
A K A ¹ Lawrence
Laurence | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 28 1979 | | 2b. HOUR
5:20PM | |
| 3 SEX
Male | 4 RACE
Caucasian | 5 DATE OF BIRTH
MONTH DAY YEAR
May 25 1919 | | 6 AGE (IN YEARS LAST BIRTHDAY)
59
YRS MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Naval Medical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U. S. Navy | | 12b. KIND OF BUSINESS OR INDUSTRY
Musician |

| | | | | | | |
|---|--|---|---|---|---|------------------------------------|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Pr. George | 13c. CITY OR TOWN
Greenbelt | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
7C Southway |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Garfield Klipp | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ethel Griffin | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
1939-59 | | 17. INFORMANT ADDRESS
22110
Larry Klipp 9603 Main St. Manassas, Va. | | |

| | | |
|---|--|---|
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>MALIGNANT MELANOMA</u>
1729
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 21</u> , 19 <u>78</u> , to <u>Jan. 28</u> , 19 <u>79</u> , that (I) (we) lost
saw the deceased <u>above</u> , (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>J. Stephan Bohan</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Jan. 29, 1979 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. STEPHAN BOHAN, M.D. | | | | 22e. ADDRESS
National Naval Medical Center, Bethesda, Md. | | | |

| | | | | | | |
|---|--|---------------------------|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
Jan 30, 1979 | 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pro Georges Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
GASCH'S FUNERAL HOME HYATTSVILLE MD | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
FEB 5 1979 <i>Henry McCreedy</i> | | | |

100-00001

January 28 1979 0:20P

1. RHP

| | | | |
|-----------|-------------------------------|-------------|---------------------------------------|
| Male | Caucasian | May 22 1912 | 28 |
| New York | NY | XX | Montgomery |
| Latitudes | National Naval Medical Center | U. S. Navy | Hospital |
| Maryland | Dr. George Grandeloff | X | W. Conway |
| Garfield | Kling | Etal | Griffin |
| Yes | 1939-50 | 117 01 4216 | Larry Cliff 2603 Main St. Kansas, Mo. |

| | | | | | | | |
|---|-----|---------|---|---------|---|---------|---|
| 1 | 111 | Jan. 20 | 7 | Dec. 21 | 7 | Jan. 28 | 7 |
| 1 | 111 | Jan. 20 | 7 | Dec. 21 | 7 | Jan. 28 | 7 |

J. STEPHAN BROWN, M.D. National Naval Medical Center, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02072
REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
William EARL Lamkin | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 20 79 | | 2b. HOUR
2:45 A.M. | |
| 3. SEX
Male | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 22 09 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
69 | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
JOHNS HOPKINS APPLIED PHYSICS | |
| 12b. KIND OF LAB OR INDUSTRY | | 13a. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13b. STATE
MARYLAND | | 13c. CITY OR TOWN
MONTGOMERY | | 13d. STREET ADDRESS
3704 ADAMS DRIVE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM E. LAMKIN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BESSIE STANG | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
577-05-6398 | | 17. INFORMANT
ADDRESS
KATHLEEN R. LAMKIN SAME AS 13 WIFE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
410-
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 HOURS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Pulmonary Edema, Chronic Obstructive Pulmonary Disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 20, 1979 to January 20, 1979 , that (I) (we) lost saw the deceased alive on JANUARY 20, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Barry Hecht MD | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/20/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARRY HECHT | | 22e. ADDRESS
10620 GEORGIA AVENUE SILVER SPRING. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
1/23/79 | | 23c. NAME OF CEMETERY OR CREMATORY
PARKLAWN CEMETERY | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROCKVILLE MONT MD. | | 23e. DATE REC'D. BY REGISTRAR
JAN 22 1979 | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | 24b. ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | 24c. REGISTRAR'S SIGNATURE
Barry Hecht | |

72-02072

EARL

WHITE

XX

U.S.A.

WASHINGTON, D.C.

JOHN HOPKINS KEPTED HUSTON

STAN ADAMS DRIVE

XX

CHICAGO

MONTGOMERY

YARLAND

STANG

DESSIE

LANKIN

WILLIAM E.

STATE AS IS

KATHLEEN E. LANKIN

277-02-2503

WANT

BROOKVILLE

LANKIN CENTRAL

102772

THIRTY

FRANKS J. COLLINS

200 LIND BLVD. W. STIVER SPRING, MD. 20687

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 79-02073
REG. NO. | |
|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR |
| Mary F LASCOLA | | | | | JAN 10 79 11:55 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| FEMALE | WHITE | MAY 11, 1900 | | 78 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MARYLAND | U.S.A. | | | MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| SILVER SPRING | UNIVERSITY NURSING HOME | | SEAMSTRESS | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS |
| MARYLAND | | MONTGOMERY | SILVER SPRING | | 1135 UNIVERSITY BOULEVARD WEST |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE | | | |
| MARIANO MERLINO | | COSEMINA PIRRONI | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 579-28-6380 | | SON BELAIR, MD. | |
| | | | | MARIO A. LASCOLA 612 PONDEROSA DRIVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Ovary with Metastases
1830
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
9 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
DERMATOMYOSITIS | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from Jan 9 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Morton A. Aitschwer | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 11/11/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Morton Aitschwer MD | | 1299 - Cambridge Dr. S. Montgomery Md 20502 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| BURIAL | | 1/16/79 | MT. OLIVET CEMETERY | | WASHINGTON, D.C. |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. DATE & SIGNATURE | |
| FRANCIS J. COLLINS | | JAN 12 1979 | | [Signature] | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | |

19-05013

1-2000

UNIVERSITY OF CALIFORNIA
SCHOOL OF MEDICINE
DEPARTMENT OF MEDICINE
DIVISION OF ENDOCRINOLOGY
1115 UNIVERSITY BOULEVARD WEST
LOS ANGELES, CALIFORNIA 90024
TELEPHONE (213) 825-1234
FAX (213) 825-1234
WWW.MEDICAL.CALIF.EDU

UNIVERSITY OF CALIFORNIA
SCHOOL OF MEDICINE
DEPARTMENT OF MEDICINE
DIVISION OF ENDOCRINOLOGY
1115 UNIVERSITY BOULEVARD WEST
LOS ANGELES, CALIFORNIA 90024
TELEPHONE (213) 825-1234
FAX (213) 825-1234
WWW.MEDICAL.CALIF.EDU

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified *immediately*.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02074
REG. NO. | |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Grace Estelle Lawless</i> | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR | | 2b. HOUR | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
JUNE 29, 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
CALVERT | | 13c. CITY OR TOWN
NORTH BEACH | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
NONE | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM HARVEY | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
IDA BARR | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | 16b. SOCIAL SECURITY NO.
578-32-8375 | | 17. INFORMANT ADDRESS
DAUGHTER SILVER SPRING, MD.
JOSEPHINE L. MUDD, 315 ST. LAWRENCE DRIVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Renal Insufficiency</i>
4409 } DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Arteriosclerotic Vascular Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 7</i> , 19 <i>76</i> , to <i>Jan 9</i> , 19 <i>78</i> , that (I) (we) last saw the deceased alive on <i>Jan 9</i> , 19 <i>78</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Bernard A. Fitzgerald MD</i> | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-9-79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BERNARD A. FITZGERALD | | | | | | 22e. ADDRESS
217 UNIVERSITY BLVD, SILVER SPRING, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
1/12/79 | | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ARLINGTON VIRGINIA | | | |
| 24. FUNERAL DIRECTOR
NAME FRANCIS J. COLLINS ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD., 20901 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>Fitzgerald</i> | | | |

LAOITAN KUTEMELKA 07/01/11 JATIM

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 79-02075 | |
|--|-----------------|---|---|--|---|--|--|--|--|--|--|-------------------|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Alban E. Lawyone | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 01 DAY 22 YEAR 1979 | | 2b. HOUR 11:30 P M | | | | | |
| 3 SEX M | 4 RACE O | 5 DATE OF BIRTH MONTH Aug DAY 6 YEAR 37 | 6 AGE (IN YEARS) LAST BIRTHDAY 41 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD Jan 23 1979 | | 2d. HOUR 11:30 P M | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Burma | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Olney | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Gen. Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) not employed | | 12b. KIND OF BUSINESS OR INDUSTRY -- | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE Md | | 13b. COUNTY Mont | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 3740 Bal Pre Rd, Apt. 5 | | | | | |
| 14. FATHER'S NAME FIRST Edward MIDDLE M. LAST Lawyone | | | | 15. MOTHER'S MAIDEN NAME FIRST Eleanor MIDDLE Bercy LAST Smith | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 182-46-4812 | | 17. INFORMANT ADDRESS Edward Lawyone same as 13e | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Dis.
4391
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
None | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | TITLE (SPECIFY) M.D. | | MEDICAL EXAMINER | | | | DATE SIGNED Jan 23/1979 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers | | ADDRESS Seminary Rd. Silver Spring, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPEC) Burial | | 23b. DATE 1/25/79 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. | | 25a. DATE REC'D. BY REGISTRAR JAN 24 1979 | | 25b. REGISTRAR'S SIGNATURE Barney McQuerry | | | | | | | | | |
| 1331 Rockville, Md. 20852 | | | | | | | | | | | | | |

79-05012

JAN 8 1979

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-02076

1. FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Grace M. Ledgard | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-24 79 | | | 2b. HOUR
11:30 P.M. | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 9, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Christian Schimpf | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Owens | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
213-74-5118 | | 17. INFORMANT
ADDRESS
Marion Mulholland Same as #13 | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Respiratory Failure
5609 DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia and
(c) Congestive Heart Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CP of Hypertension for Intestinal Obstruction of Perforated Cecum & Sigmoid | | | | | | | | |
| 19a. DATE OF OPERATION
1/18/79 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Intestinal Obstruction | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
P.M. 19 | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/18/79 to 1/24/79, that (I) (we) last saw the deceased alive on 1/24/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Robert A. Barnett, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/25/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert A. Barnett, M.D. | | | | 22e. ADDRESS
3906 Bel Pre Rd Wheaton, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/29/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenwood Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lancaster, Pennsylvania | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | | | 25a. DATE RECEIVED BY REGISTRAR
FEB 1 1979 | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur McBrady | | | | |

79-05076

Enclosure April 1, 1951

Dr. J. H. Hospital

Mayfield Hospital, Knoxville, Tenn.

Dear Sir:

245-71-11

79-05076

Robert A. Thompson, Hospital

Mayfield Hospital, Knoxville, Tenn.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-02077 | |
|--|---------|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2b. DATE KNOWN OF DEATH | | 2c. DATE ESTIMATED | |
| Claire | | | | | | Levy | | X 1 28 79 | | 5:25 a. M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2d. DATE PRONOUNCED DEAD | |
| female | white | MAY 5, 1954 | | 24 YRS. | | | | | | 1 28 79 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | XX | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| EGYPT | | USA | | WIDOWED | | DIVORCED | | | | Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | | at home/8309 Eastern Ave., Apt 202 | | | | | | PROGRAMER | | COMPUTERS | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| MARYLAND | | MONTGOMERY | | SILVER SPRING | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 8039 EASTERN AVE., APT. 202 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | |
| MAURICE | | | | LEVY | | | | SUZANNE MASSOUDA | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | MAX SUGARMAN | | FUNERAL HOME | | | |
| NO | | | | 485 HOPE ST., PROVIDENCE, RI | | 02906 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ligature strangulation</u> | | | | | | | | | | | |
| 963- } DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | |
| | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY (est) HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | ? 1/28/ 79 | | found strangled | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | |
| | | at home | | 8309 Eastern Ave, Apt 202 | | Silver Spring | | MontCo | | MD | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | |
| Virginia L. Dolan | | Assistant | | 1/28/79 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | |
| Virginia L. Dolan, M.D. | | 111 Penn Street, Balto., MD 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | |
| REMOVAL | | JAN. 31, 1979 | | LINCOLN PARK | | WARWICK | | Rhode Island | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| SOL LEVINSON & BROS., INC. | | 1601 REISTERSTOWN RD., BALTO., MD 21215 | | | | FEB 1 1979 | | | | | |

77050-27

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

DHMH-16 60M 1/73
(VR A 15 (4))



| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02078 | |
|--|--|---|--|---|--|---|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Alfaretta M. Lockwood | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 30, 1979 | | | 2b. HOUR
5:30 P | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 26 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 72 HRS
HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Dakota | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Potomac Valley Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Asst. Town Clk. | | 12b. KIND OF BUSINESS OR INDUSTRY
Potsdam, N.Y. | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10423 Kardwright Court | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frederick McCall | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Kathryn Jane Corey | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
09 4-20-9623 | | 17. INFORMANT
ADDRESS
Jean L. Swinebroad (same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular accident
436-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hrs
5 yrs | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/1/78 to 4/30/79 , that (I) (we) lost
saw the deceased alive on 4/30 19 79 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Myron L. Lenkin | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
1/30/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Myron L. LENKIN | | | | | 22e. ADDRESS
509 SHOREFIELD RD
WHEATON MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | | 23b. DATE
2-1-79 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA FAIRFAX VIRGINIA | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
ROBERT A. PUMPHREY FUNERAL HOMES P/A | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1979 | | 25b. REGISTRAR'S SIGNATURE
History McCreedy | | | | |

79-02078

Lockwood

Albion

Albion

Rockville

Rockville

Rockville

Rockville

Rockville

Rockville

NAME: Martha Louise Loder

DATE OF DEATH: January 20, 1979

PLACE OF DEATH: Montgomery County

SEE: #79-04722
February, 1979
Montgomery County



Released by Dr Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-02079

| | | | | | |
|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| I. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | 2:20 PM | |
| Bessie Long | | 1 13 79 | | | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Female | Caucasian | Aug. 18 1886 | 92 | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A. | | Suburban Hospital MONT. MD. | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | Suburban Hospital | Saleslady | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| Md. | Balt. | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 4139 Marx Ave. | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| Thomas Robosson | | Emma C. Bell | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17 INFORMANT | | |
| No | | 219-22-6987 | Asbury Meth. Home, 301 Russell Ave., Gaithersburg, Md. 20760 | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral-Vascular Accident</u>
436-
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 hours |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 11/13/79</u> to <u>4/13/79</u> , that (I) (we) last saw the deceased alive on <u>4/13/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>Thos G. Ward</u> | | | | 1/13/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Thos G. Ward | | 6116 Robin Ward Rd, Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION |
| Burial | | Jan. 16, '79 | Western Cemetery | | CITY OR TOWN COUNTY STATE |
| | | | | | Baltimore Balt. Maryland |
| 24 FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Gartner-Sandison F.H. | | JAN 19 1979 | | <u>John J. Brady</u> | |
| | | 316 E. Diamond Avenue, Gaithersburg, Md. | | | |

79-02079

1 12 79

Long

Resale

Suburban Hospital

Suburban Hospital

Resale

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMM - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-02080

| | | | | | | | | | | | |
|---|-------------------------------------|---|---------------------------------------|--|---|---|--|--|---|--|---------------------------------|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
BILLY | MIDDLE
BORROUN | LAST
LONG | 2a. DATE OF DEATH | MONTH
JANUARY | DAY
15, | YEAR
1979 | 2b. HOUR
10:35 ^{PM} |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH
FEBRUARY | DAY
15, | YEAR
1930 | 6. AGE (IN YEARS LAST BIRTHDAY)
48 | 7. IF UNDER 1 YEAR
MONTHS
DAYS | 8. IF UNDER 24 HRS.
HOURS
MIN. | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mississippi | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CLINICAL CENTER, NIH | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Letter Carrier | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't | | |
| 13a. STATE
ARKANSAS | | 13b. COUNTY
Miss. | | 13c. CITY OR TOWN
BLYTHEVILLE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1812 NORTH 10th STREET | | | |
| 14. FATHER'S NAME
FIRST
Theodore | | MIDDLE
Long | | 15. MOTHER'S MAIDEN NAME
FIRST
Lela | | MIDDLE
Putt | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | |
| 16b. SOCIAL SECURITY NO.
Not Available | | 17. INFORMANT
ADDRESS
Aurita Long same as item 13 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
2019
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF Lung carcinoma
(c) DUE TO, OR AS A CONSEQUENCE OF Hodgkin's disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 months
1 year | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
CITY OR TOWN
COUNTY
STATE | | 22a. I certify that (this hospital) attended the deceased from NOVEMBER 9 19 78, to JANUARY 15 19 79, that (we) last saw the deceased alive on JANUARY 15 19 79, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death. | |
| 22b. SIGNATURE
Joan M. Bull MD | | DEGREE | | 22c. DATE SIGNED
1/16/79 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joan Bull MD | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH
CLINICAL CENTER, BETHESDA, MARYLAND | | 22f. DATE RECEIVED BY REGISTRAR
JAN 22 1979 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/19/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Elmwood Cemetery | | 23d. LOCATION
Blytheville, Arkansas | | 23e. DATE RECEIVED BY REGISTRAR
JAN 22 1979 | | 23f. REGISTRAR'S SIGNATURE
Harry McCreedy | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | 24b. DATE RECEIVED BY REGISTRAR
JAN 22 1979 | | 24c. REGISTRAR'S SIGNATURE
Harry McCreedy | | 24d. DATE RECEIVED BY REGISTRAR
JAN 22 1979 | | 24e. REGISTRAR'S SIGNATURE
Harry McCreedy | | 24f. DATE RECEIVED BY REGISTRAR
JAN 22 1979 | |

79-05080

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 7/77

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-02081
REG. NO.

| | | | | | | | | | |
|---|---------|--|--|---|--|---|--|--|--|
| 1- STATE REGISTRAR | | FOR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | 79-02081 | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | |
| Ruth M. Long | | | | | | | | <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR
<input type="checkbox"/> JAN 5 1979 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR | | IF UNDER 24 HRS. | |
| F | W | JULY 19 1901 | | 78 YRS. | | MONTHS | | DAYS | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Baltimore Md. | | U.S.A. | | WIDOWED | | DIVORCED | | Montgomery MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| S. Y. Spgs. | | Holy Cross Hosp | | Retired (Purdue Univ.) | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md. | | Mont. | | Rockville | | YES | | 4818 Oxbow Rd | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| John D. Owens | | Mary McQuade | | 577-36-0961 | | Roger E. Speer (Son) | | B.e. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| No | | 577-36-0961 | | Roger E. Speer (Son) | | B.e. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1 DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 481- | | Pneumococcal Pneumonia with | | Septicemia | | 3 days | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | None | | None | | None | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES | | NO | |
| None | | None | | YES | | NO | | X | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | |
| | | HOUR A.M. MONTH DAY YEAR | | P.M. 19 | | WHILE AT WORK | | STREET, FACTORY, FARM, ETC.) | |
| 21f. LOCATION | | 21g. PLACE OF INJURY | | 21h. LOCATION | | CITY OR TOWN | | COUNTY | |
| | | STREET, FACTORY, FARM, ETC.) | | STREET | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy | | Inspection | | Inquiry | | and in my opinion | |
| death resulted from: | | Natural causes | | Accident | | Suicide | | Homicide | |
| | | X | | | | | | Undetermined manner | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | M.D. | | | |
| Ruth M. Long | | Dep. | | JAN 5, 1979 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| | | | | Burial | | Jan. 8-1979 | | Mt. Olivet | |
| 24. FUNERAL DIRECTOR | | 25. DATE REC'D. BY REGISTRAR | | 26. REGISTRAR'S SIGNATURE | | 27. ADDRESS | | | |
| Robert Walters | | JAN 10 1979 | | Murray McCready | | 254 Carroll St. Bk. | | | |

BP

79-02081

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02082 | | | |
|--|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) William Loomis | | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN. 13, 1979 | | 2b. HOUR 11:45 AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 11 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH S.S. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) #1 Whittingham Terrace | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Barber | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS #1 Whittingham Terrace | |
| 13a. STATE Md. | | 13b. COUNTY Mont | | 13c. CITY OR TOWN S.S. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Panagiotis Loumakos | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margarita Pieroutsakou | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579 44 2922 | | 17. INFORMANT ADDRESS Evangelia Loomis (Wife) Same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) AZOTEMIA
600-
DUE TO, OR AS A CONSEQUENCE OF
(b) CHRONIC RENAL FAILURE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) HYDRONEPHROSIS
BENIGN PROSTATIC HYPERTROPHY | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 MTHS
10 MTHS
20+ YRS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS | | | | | | | |
| 19a. DATE OF OPERATION NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. — 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from JULY 1974 to 1-13 1979 , that (1) (we) last saw the deceased alive on JAN 12 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John B. Nasou, MD | | | | DEGREE — | | 22c. DATE SIGNED 1-13-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN B. NASOU, MD | | | | 22e. ADDRESS 800 PERSHING DR SILVER SPRING, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/17/79 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | 23d. LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi F.H. 11800 N.H. Ave. Silver Spring, Md. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 17 1979 | | 25b. REGISTRAR'S SIGNATURE History McCreedy | |

19-05085

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02083
REG. NO. | | | |
|--|--|---|--|---|--|--|---|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Homer F LUDWIG | | | | 1-10-79 8 ⁰⁵ P.M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Aug 7, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Service station | | 12b. KIND OF BUSINESS OR INDUSTRY
owner | |
| 13a. STATE
Md | | | | 13b. COUNTY
Pro Georges | | 13c. CITY OR TOWN
Beltsville | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Oliver J Ludwig | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lucinda Ice | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
23 301 4028 | | 17. INFORMANT ADDRESS
Helen Ludwig Beltsville, Md. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) <u>Carcinoma of Right Lung</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/12/79 to 1/16/79, that (I) (we) lost the deceased alive on 1/16/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Alan W. Estock MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/11/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Alan W. Estock MD | | | | 22e. ADDRESS
1295 Lumberton Dr. Silver Spring MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan 13, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Brentwood Pro Georges Md. | |
| 24. FUNERAL DIRECTOR NAME
F. Gasch's Sons P A Hyattsville, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1979 | | 25b. REGISTRAR'S SIGNATURE | |

78-02083

STANDARD FORM NO. 64

DATE

TO

FROM

SUBJECT

RE

ATTENTION

REFERENCE

NOTES

COMMENTS

APPROVED

SPECIAL AGENT

IN CHARGE

SPECIAL AGENT

IN CHARGE

DATE

TO

FROM

SUBJECT

RE

ATTENTION

REFERENCE

APPROVED

SPECIAL AGENT

IN CHARGE

SPECIAL AGENT

IN CHARGE

DATE

TO

FROM

SUBJECT

RE

ATTENTION

REFERENCE

APPROVED

SPECIAL AGENT

IN CHARGE

SPECIAL AGENT

IN CHARGE

DATE

TO

FROM

SUBJECT

RE

ATTENTION

REFERENCE

APPROVED

SPECIAL AGENT

IN CHARGE

SPECIAL AGENT

IN CHARGE

DATE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 47 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 79-02084 | |
|--|--------|-----------------------------------|--|---|--|---|---|---|-----------------------------------|--|----------|
| 1- STATE REGISTRAR | | | | | | | | | | RECEIVED NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR |
| Shirley | | | Salus | | Lynn | | | | MONTH DAY YEAR
1/11 19 79 | | M |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH
MONTH DAY YEAR | 6 AGE (IN YEARS)
LAST BIRTHDAY | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN | 2c. DATE PRONOUNCED DEAD | | MONTH DAY YEAR | | 2d. HOUR | |
| Female | White | Sept. 17, 1924 | 54 YRS. | | | 1/11 19 79 | | 11:55 | | P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Washington, D.C. | | | USA | | | | Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Chevy Chase | | | 5515 Surrey Street | | | | Social Worker | | USGovt. | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| Maryland | | Montgomery | | Chevy Chase | | | | 5515 Surrey Street | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | |
| Jeremiah ----- Salus | | | | Rebecca ----- Offenberg | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | | | 578-38-1144 | | Arnold Salus - 8909 Cherbourg Drive Potomac, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Carcinoma of the lung.</u> | | | | | | | | | | 4 months | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| None | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| None | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | | | | None | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | |
| | | | | M.D. Deputy | | | | 1/12/79 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| John S. Rogers, M.D. | | | | 1919 Seminary Road Silver Spring, Montgomery, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | | 1-14-79 | | King David Mem. Gdn. | | | Falls Church Virginia | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Danzansky-Goldberg Mem. Chap. Rockville, Md. | | | | 1170 Rockville Pike | | | | JAN 16 1979 | | | |

18050-02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|--|---|---|--|
| 1. FOR STATE REGISTRAR | | 79-02085 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Irene L. Lypowy | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
January 29, 1979 | | | 2b. HOUR
2:35a M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
November 5, 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY)
49 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Clinical Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE New Jersey 13b. COUNTY Passaic 13c. CITY OR TOWN Ringwood | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
23 Robin Lane | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Daniel Yaroschewich | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Jennie Kaniecki | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
147-22-3016 | | 17. INFORMANT ADDRESS
Mr. William Lypowy (same as pt.) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1830
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DO NOT WRITE
(c) Ovarian Carcinoma, metastatic | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.A. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from October 18, 1978 , to January 29, 1979 , that (we) lost saw the deceased alive on January 29, 1979 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) did (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
F. G. BARR | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
1/29/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
F. G. BARR | | | | 22e. ADDRESS
National Institutes of Health Clinical Center, Bethesda, MD 20014 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2-2-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
North Arlington, N.J. | | | |
| 24. FUNERAL DIRECTOR NAME
ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland | | | | 25a. DATE RECEIVED BY REGISTRAR
1979 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

BP

79-05082

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR
1- STATE REGISTRAR | | | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | 79-02086
ETHEL M. MABERRY | | | |
|--|--|---------|--|------------------|--|--|--|----------------|--|------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | | FIRST MIDDLE LAST | | | | | | 2a. DATE KNOWN OF DEATH | | | | | | 2b. HOUR | | | | | | | | | |
| Ethel M. Maberry | | | | | | | | | | | | Jan 5 1979 | | | | | | 4:30 PM | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | | | | | 7d. HOUR | | | | | | | | | |
| F | | W | | July 2 16 | | 62 YRS | | MONTHS | | DAYS | | Jan 5 1979 | | | | | | 2:30 PM | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| PENNA | | | | | | U.S.A | | | | | | | | | | | | Montgomery MD | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Sil. Spg | | | | | | 831 Northampton Dr. HOME MAKER | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | | | 13b. COUNTY | | | | | | 13c. CITY OR TOWN | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| Md | | | | | | Mont. | | | | | | Sil. Spg | | | | | | 831 Northampton Dr. | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | |
| FIRST MIDDLE LAST | | | | | | FIRST MIDDLE LAST | | | | | | 16c. ADDRESS | | | | | | | | | | | | | | | |
| SMITH | | | | | | IDA | | | | | | NO | | | | | | 189-12-9058 | | | | | | | | | |
| 17. INFORMANT | | | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| NORMAN F. MABERRY | | | | | | 831 NORTHAMPTON DR | | | | | | | | | | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | IMMEDIATE CAUSE (a) | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| 4291 | | | | | | Acute Myocardial Dis. | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | (b) | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| | | | | | | Chronic Myocardial Dis. | | | | | | 7 yrs. | | | | | | | | | | | | | | | |
| | | | | | | (c) | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | None | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | | | | | | | | | | | | | |
| None | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| | | | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | P.M. 19 | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | STREET | | | | | | CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | TITLE (SPECIFY) | | | | | | DATE SIGNED | | | | | | | | | | | | | | | |
| JOHN ROGERS | | | | | | M.D. Doc | | | | | | Jan 5, 1979 | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | ADDRESS | | | | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | 23b. DATE | | | | | | | | | |
| JOHN ROGERS | | | | | | | | | | | | Burial | | | | | | Jan. 9, 1979 | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | 23d. LOCATION | | | | | | 23e. DATE REC'D. BY REGISTRAR | | | | | | 23f. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Fort Lincoln Cemetery | | | | | | Brentwood, MD | | | | | | Jan 11 1979 | | | | | | Judy | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| Takara Funeral Home, J. G. Walters | | | | | | 25c. ADDRESS | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | 25d. ADDRESS | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | 254 Canal St. NW Dr | | | | | | | | | | | | | | | | | | | | | |

28020-2

187-15-1075

187-15-1075

187-15-1075

187-15-1075

187-15-1075

187-15-1075

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02087
REG. NO. | |
|--|--|---|--|---|--|--|---|--|--|----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Alice. M. MacQuilliam | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/4/79 | | | 2b. HOUR 11:30 AM | | | |
| 3 SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 3 9 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Clerk - Dept. Store- | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13a. STREET ADDRESS | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Pr. Geo. | | 13c. CITY OR TOWN College Park | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6100-West Chester Park Dr. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George H. Rehrey | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary M. McIntyre | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 579-10-1957 | | 17. INFORMANT ADDRESS William J. MacQuilliam - above address | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Broncho pneumonia -
4/40 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Congestive heart failure
(c) Coronary heart disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks.
a wk.
years. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Poor kidney function - recurrent small stroke - liver insufficiency | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/18/78 19 to 1/4/79 1979, that (I) (we) last saw the deceased alive on 1/4/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Faruk T. Ozer M.D. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1/5/79. | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FARUK T. OZER | | | | 22e. ADDRESS 11125 Rockville Pike Rockville, Md. 20852 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/8/79 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md. | | | | |
| 24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc. | | | | ADDRESS Mt. Rainier, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 10 1979 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

78050-25

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | | | |
|---|--|----------------------|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) GERTRUDE M. MacVEIGH | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 1 22 19 79 | | 2b. HOUR 3:30 PM | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH 7 DAY 22 YEAR 93 | | 6. AGE (IN YEARS) LAST BIRTHDAY 85 YRS. | | 7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/> | | 7c. DATE PRONOUNCED DEAD Jan. 22 19 79 | | 2d. HOUR 3:30 PM | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | | | |
| 13a. STATE Maryland | | | | | | | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Bethesda | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6716 Michaels Drive | |
| 14. FATHER'S NAME FIRST Edward MIDDLE Greene LAST Greene | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Katherine MIDDLE Kosters LAST Kosters | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 215-46-0282 | | | | 17. INFORMANT Son ADDRESS Md. | | | | 17b. George E. MacVeigh, 9313 Renshaw Dr. Beth. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Infarction Rt. Hemisphere | | | | | | | | | | | | 36 H. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Fracture of Left Hip | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Hypertensive Cardiovascular Disease | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Hypertensive cardiovascular disease | | | | | | | | | | | | | | | | | |
| (c) Fracture of Left Hip | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| Diabetes Mellitus | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR 6 P.M. Jan 12 19 79 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fall at home - Fracture of Hip | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | | | 21i. LOCATION 6716 Michaels Drive CITY OR TOWN Bethesda COUNTY Mont. STATE Md. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John G. Ball | | | | TITLE (SPECIFY) M.D. | | | | MEDICAL EXAMINER | | | | DATE SIGNED Jan 22, 1979 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D. | | | | ADDRESS 7936 Old Georgetown Rd., Bethesda, Md. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/26/1979 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | | | | 23d. LOCATION CITY OR TOWN Silver Spring COUNTY Md. STATE Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME JOSEPH CAWLER'S SONS INC. ADDRESS 5130 WISC. AVE., N. W. WASH., D. C. 20016 | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 29 1979 | | | | 25b. REGISTRAR'S SIGNATURE Jeffery McCreedy | | | | | | | |

88050-27

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02089
REG. NO. | |
|---|--|---|--|--|---|
| 1. FOR STATE REGISTRAR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | 2b. HOUR |
| FIRST MIDDLE LAST
Virginia L Maffei | | | MONTH DAY YEAR
01/02/79 | | 9 ¹⁰ PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR
MONTHS DAYS |
| Female | White | MONTH DAY YEAR
2 25 1916 | 62 YRS | | IF UNDER 74 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Oklahoma | USA | | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Silver Spring | Holy Cross Hospital | | Cashier | | Restaurant |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13d. STREET ADDRESS | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| Maryland | Montgomery | Rockville | 4518 Adrian Street | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| Charles F. Perkins | | Nellie Bray Maloney | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | |
| No | | 558 05 7649 | | Julie Weiss Same as item # 13 a-e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Disseminated intravascular coagulation</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of breast</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Hours</u>
<u>Months</u>
<u>12 yrs.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a-e) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 1958</u> to <u>Jan 2 1979</u> , that (I) (we) last saw the deceased alive on <u>1/2 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>Richard P. Delaney MD</u> DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| RICHARD P. DELANEY MD | | 4323 HAVARD ST. S. S. 20906 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| Burial | | 1-5-79 | Gate of Heaven Cem. | | Silver Spring Maryland |
| 24. FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Md. 20852 | | | JAN 8 1979 | | <u>Richard P. Delaney</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #5&11 per phone call w/Fun.

FOR Home 2/1/79 rc
1 - STATE REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFRANCIS M. MAGRUM
REG. NO. 79-02050

| | | | | | | | |
|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Francis M. Magrum | | | 2a. DATE OF DEATH MONTH 1 DAY 22 YEAR 79 | | | 2b. HOUR 255 P.M. | |
| 3. SEX male | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH 12 DAY 15 YEAR 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INSPECTOR - WASH. GAS CO. | | 12b. KIND OF BUSINESS OR INDUSTRY (RET.) | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD COUNTY mont. | | 13b. CITY OR TOWN Bethesda | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 9306 Ewing Dr | |
| 14. FATHER'S NAME FIRST ALBERT MIDDLE MAGRUM LAST MAGRUM | | 15. MOTHER'S MAIDEN NAME FIRST NINA MIDDLE HARPER LAST HARPER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO 577-07-7907 | | 17. INFORMANT ADDRESS MARGUERITE W. MAGRUM 9306 EWING RD. BETH | | | | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1629
(b) Oat cell carcinoma of left lung
DUE TO, OR AS A CONSEQUENCE OF
(c) " | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
SEVERAL
"
" | |
|--|--|--|--|

| | | | |
|--|--|---|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH 12 DAY 19 P.M. | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/22 , 19 72 , to 1/22 , 19 79 , that (I) (we) lost saw the deceased alive on 1/22 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE C. J. J. J. J. DEGREE MD | | 22c. DATE SIGNED 1-25-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 26, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY BALTIMORE STATE MD. | |
| 24. FUNERAL DIRECTOR NAME Takoma Funeral Home, J. G. Walter ADDRESS 2500 Carroll Rd NW DC | | 25a. DATE REC'D. BY REGISTRAR JAN 25 1979 | | 25b. REGISTRAR'S SIGNATURE Henry McCreedy | | | |

10-05030

H
10/1/71
L. Z. M.

(10/1) 10/1/71

10/1/71 10/1/71 10/1/71 10/1/71

10/1/71 10/1/71 10/1/71 10/1/71

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02091
REG. NO.

| | | | | | | |
|--|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Benjamin W. Malickson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan. 20 1979 | | 2b. HOUR
4:27A M | |
| 3 SEX
Male | 4 RACE
White | 5 DATE OF BIRTH
MONTH DAY YEAR
Sept. 15, 1897 | | 6 AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Real Estate | | 12b. KIND OF BUSINESS OR INDUSTRY
Real Estate | |
| 13a. STATE
Md | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Ephraim Malickson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Raisel | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
577-12-4982 | | 17. INFORMANT
ADDRESS
Mrs. Sophie Malickson Same as No. 13 | | |

| | | |
|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
<u>402 -</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>HYPERTENSIVE AND ARTERIO-SCLEROTIC HEART DISEASE</u>
(c) <u>1 YEAR</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 19 1979</u> to <u>JAN 20 1979</u> , that (I) (we) lost saw the deceased alive on <u>JAN 19 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Robert L. Krichmar MD</u> | | | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED
<u>1/20/79</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>ROBERT L. KRICHMAR MD</u> | | | | 22e. ADDRESS
<u>7733 ALASKA AVENUE N.W.</u>
<u>WASHINGTON D.C. 20012</u> | | | |

| | | | | | | | |
|--|--|------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/21/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Beth Shalom Cong. Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hillside, Maryland | |
| 24. FUNERAL DIRECTOR
Donald M. Stein Hebrew Memorial F.H. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 29 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |
| 232 Carroll Street, N. W. Washington, D. C. | | | | | | | |

12050-27

2000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH 17
(VR A15 ME (5))
15M 7/77

FOR
1- STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-02092

| | | | | | | | | | | | | |
|--|-------------------------|---|-------------------------|---|---|---|---|--|------------------|---|-------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Ethel | MIDDLE
Marion | LAST
Margraf | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> ESTI-MATED | MONTH
Jan | DAY
16 | YEAR
1979 | 2b. HOUR
4:48 | |
| 3. SEX
F | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH
Jan DAY
1 YEAR
1962 | | 6. AGE (IN YEARS LAST BIRTHDAY)
17 YRS. | IF UNDER 1 YR.
MONTHS
0 DAYS
0 | IF UNDER 24 HRS.
HOURS
0 MIN.
0 | | 7c. DATE PRONOUNCED DEAD
Jan 16, 1979 | | 2d. HOUR
4:48 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Tak Park | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wash Advent Hosp | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | | 12b. KIND OF BUSINESS OR INDUSTRY
U S Gov't. | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | |
| 13a. STATE
Md | | 13b. COUNTY
Pro Georges | | 13c. CITY OR TOWN
Riverdale | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6012 Taylor Road | | | | |
| 14. FATHER'S NAME
FIRST
Charles E MIDDLE
Rife LAST | | | | | 15. MOTHER'S MAIDEN NAME
FIRST
Frances MIDDLE
Spathek LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
354 09 7382 | | 17. INFORMANT
Robert E Margraf ADDRESS
Riverdale, Md. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
4412
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) Surgery for Aortic Valve Replacement
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
Aneurysm Ascending Aorta | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
1-16-79 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
Aortic Aneurysm Ascending | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET
CITY OR TOWN
COUNTY
STATE | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE
John S. Rogers | | TITLE (SPECIFY)
MD. | | MEDICAL EXAMINER | | | | DATE SIGNED
Jan 17, 1979 | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | John S. Rogers | | ADDRESS
1919 Semnry Rd. SilSp, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Jan 20, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN
Brentwood Pro Georges | | COUNTY
Md. | | STATE | | |
| 24. FUNERAL DIRECTOR
NAME
F. Gasch's Sons P A Hyattsville, Md. | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
JAN 23 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | |

19-05085

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02093 | |
|---|--|---|--|---|---|---|--|--|----------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) LIZZIE MASER | | | | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | | |
| | | | | | JAN 25 19 | | 235 | | P M | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 3, 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Hebrew Home of Greater Washington | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5015 Battery Lane | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Moses ----- Sherby | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Edith ----- Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO.
578-46-5663B | | 17. INFORMANT
ADDRESS Washington, D. C.
Dorothy Vogt, 5415 Connecticut Ave. N.W. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic hepatic carcinoma
1552
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 mo. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (he) (this hospital) attended the deceased from 11/14 , 19 73 , to 1/25 , 19 79 , that (he) (we) lost
saw the deceased alive on 1/25 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Maurice Franks | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/25/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Maurice Franks, MD | | | | | | 22e. ADDRESS
6121 Monroe Rd, Rockville Md 20852 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
1-28-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Lebanon Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hyattsville, P.G. Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Mem. Chap. Rockville, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 31 1979 | | 25b. REGISTRAR'S SIGNATURE
Heston McCreedy | | | |

10-05003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02094
REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Marvin Lewis Mathsen, Sr. | | | | 2a. DATE OF DEATH MONTH DAY YEAR
January 29, 1979 | | | |
| 3. SEX
Male | | | | 2b. HOUR P
6:55 M | | | |
| 4. RACE
Caucasian | | | | 5. DATE OF BIRTH MONTH DAY YEAR
7/13/1899 | | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Manor Care Nursing Home | | | |
| 12a. USUAL OCCUPATION (TYPE OF OCCUPATION OR WORKING LIFE)
Engineer | | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Navy | | | |
| 13a. STATE
Maryland | | | | 13b. CITY OR TOWN
Kensington | | | |
| 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13d. STREET ADDRESS
3205 Fayette Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Martin Mathsen | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Louisa Lett | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
1918-1959 | | | |
| 17. INFORMANT ADDRESS
Irene L. Mathsen, same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
4292 } DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
(c) DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 HRS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | |
| 21f. LOCATION STREET | | | | 21g. CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from January 22, 1979, to January 29, 1979, that (I) (the) lost saw the deceased alive on January 29, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Walter E. Goozh | | | | 22c. DATE SIGNED
1-30-79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Walter E. Goozh | | | | 22e. ADDRESS
2309 Shorefield Road
Wheaton, Maryland 20902 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
2/1/79 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l. Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Arlington, Virginia | | | |
| 24. FUNERAL DIRECTOR NAME
ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1979 | | | |
| 25b. REGISTRAR'S SIGNATURE
P. A. Pumphrey | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-02095 | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Theodore Henry Mattheiss | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
01 06 79 | | | 2b. HOUR
5:48pm | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
10 26 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
EXC. SEC. | | 12b. KIND OF BUSINESS OR INDUSTRY
Relig. Org. | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Sandy Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
17100 Quaker Lane | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Theodore H. Mattheiss Sr. | | | | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST
Wilhelmina Hahn | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
219-01-2578 | | 17. INFORMANT ADDRESS
Naomi M. Mattheiss Same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
4149
DUE TO, OR AS A CONSEQUENCE OF (b) REFRACTORY VENTRICULAR FIBRILLATION 11HR
DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
INSTANT | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
--- | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
--- | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 6 19 79 to JAN 6 19 79 , that (I) (we) lost saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
S. Sabatier MD | | | | DEGREE
MD | | | | 22c. DATE SIGNED
1-7-79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HENRY S SABATIER | | | | 22e. ADDRESS
18101 PR. PHILIP DR OLNEY, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Jan. 10, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Friends Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Sandy Spring Mont. Md. | | | |
| 24. FUNERAL DIRECTOR NAME
Francis H. Barber | | | | | | ADDRESS
Laytonsville, Md. 20760 | | 25a. DATE REC'D. BY REGISTRAR
JAN 10 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>Anthony McCreedy</i> | |

78-05092

Items #10a-22a Film 0531 5/11/79 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-02096

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|---|--|--|--|--------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Donald | | | | | | McClellan | | ESTIMATED | | <input type="checkbox"/> | | 1 | | 25 | | 1979 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | MONTH | | DAY | |
| Male | | Black | | 4-14-56 | | 22 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | 1 25 19 79 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 2d. HOUR | |
| S. C. | | U.S.A. | | | | Montgomery County | | Takoma Park | | Washington Adventist Hospital | | | | | | 5:08 AM | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| Md. | | Montg. | | Gaithersburg | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 786 Kimberly Court-East | | FIRST | | MIDDLE | | LAST | | 17. INFORMANT | |
| Henry McClellan | | Edith Smith | | ADDRESS | | Carver Johnson (Brother-in-law) same as #13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1 DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) <u>Undetermined</u> | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 7999 | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | 1/25/79 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | 111 Penn Street | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| Removal | | 1-27-79 | | Jackson-McGill Fun. Home | | Marion | | Marion | | S. C. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| George R. Snowden | | 246 N. Washington St. Rockville, Md. 20850 | | JAN 29 1979 | | History McCreedy | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1a-05008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02097
REG. NO. | |
|---|--|--|--|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mary S. McGee | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-3-79 | | 2b. HOUR
9:30p M | | | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 30 1896 | | 6 AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Pennsylvania | | | | | 13b. COUNTY
Clairton | | 13c. CITY OR TOWN
Clairton | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph McClaine | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna McCormick | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
195 40 6232 | | 17. INFORMANT
11501 Stonewood Lane
Jacqueline Ford Rockville, Maryland 20852 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMATOSIS
1572
DUE TO, OR AS A CONSEQUENCE OF
(b) CARCINOMA TAIL PANCREAS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
UNK
UNK | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1/3/79 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/29/78, 19, to 1/3/79, 19, that (I) (we) lost saw the deceased alive on 1/3/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Henry C. Scruggs MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
1/4/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HENRY C. SCRUGGS MD | | | | | | 22e. ADDRESS
5413 Cedar Lane Bethesda Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
1-6-1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Calvary Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pittsburg Pennsylvania | | | |
| 24. FUNERAL DIRECTOR
NAME
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Md. 20852 | | | | | | 25a. DATE REC'D BY REGISTRAR
JAN 8 1979 | | | 25b. REGISTRAR'S SIGNATURE | | |

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-02098
REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---------------------|--|---------|--|---|--|------------------------------------|--|----------------------------------|--|----------------------------------|--|-------------------------|--|--------------------|--|----------|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1/2 1979 | | | | | | | | | | 2b. HOUR OF DEATH 5:45 PM | | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS
LAST BIRTHDAY) | | 7. IF UNDER 1 YR.
MONTHS DAYS | | 8. IF UNDER 24 HRS.
HOURS MIN | | 9. DATE PRONOUNCED DEAD | | 10. MONTH DAY YEAR | | 11. HOUR | |
| Arthur William McKee | | | | | | | | M | | W | | 12 13 14 | | 64 YRS. | | | | | | Jan. 2 1979 | | 5:45 PM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | |
| Minn. | | USA | | | | Montgomery County MD. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| Bethesda, Md. | | Suburban Hospital | | Funeral Director | | S.H.Hines | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | | | | | | | | | | | |
| Md | | Mont | | Bethesda | | | | 4853 Cordell Ave. | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | | | | | | | | | | | | | | | |
| Henry McKee | | Christine Strom | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | 17. ADDRESS | | | | | | | | | | | | | | | | | | | |
| Yes | | W.W.11 | | 502-05-7313 | | Luella M. McKee (Wife) | | Same as above | | | | | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u>
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cardio Vascular Disease.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | | | | | | | | | |
| John G. Ball | | M.D. Deputy | | Jan. 2, 1979 | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | |
| John G. Ball | | 7936 Old Geo. Rd. Bethesda, Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | |
| Cremation | | 1/4/79 | | Ft. Lincoln Crematory | | Brentwood PG | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | |
| Hines/Rinaldi F.H. | | 11800 N.H. Ave. Silver Spring, Md. | | | | | | | | | | | | | | | | | | | | | | | |

88050-07

157 212

200.

702-1119

Technology Center

Figure 1

Feb 1994

(827 Cordell Ave.

0123456789

200

10532

11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02099 | |
|---|--|--|--|---|--|--|--|--|---|---|--|
| FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
Marguerite B. McKeever | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
01-18-79 | | | 2b. HOUR
6:45 P.M. | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
June 2, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | | 12b. KIND OF BUSINESS OR INDUSTRY
N R A | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13a. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13b. STREET ADDRESS
1817 N. Quinn Street | | |
| 13a. STATE
Virginia | | 13b. COUNTY
Arlington | | 13c. CITY OR TOWN
Arlington | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Thomas Moreland | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Rena Benton | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
579-22-7762 | | 17. INFORMANT ADDRESS
Patricia M. Chalk 2500 Forest Glen Rd.
Silver Spring, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma to Brain</u>
1991
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Unknown Primary Site</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 months
3+ months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/18/78</u> to <u>1/19/79</u> , that (I) was last saw the deceased alive on <u>1/12/79</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>G. Lennard Gold, MD</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/19/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G. Lennard Gold | | | | | | 22e. ADDRESS
8630 Fenton St. Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
1-18-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria Alexandria Va. | | | | | |
| 24. FUNERAL DIRECTOR NAME
FRANCIS J. COLLINS | | | | | | 25a. DATE REC'D. BY REGISTRAR
2/11/2090 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |
| 500 UNIVERSITY BLVD. W. SILVER SPRING, MD. JAN 22 1979 | | | | | | | | | | | |

19-05000

01-11-75

45

June 9, 1975

White

Female

Montgomery

xxxx

USA

Washington

NRA

Club

Washington

Silver Spring

1919 N. Capitol Street

x

Washington

Washington

Virginia

Fortran

Fortran

Fortran

Thomas

1919 Fortran Club
Silver Spring, Md.

Fortran Club

Fortran Club

Mc

1- FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-02100

| | | | | | | | | | | | | | | | |
|--|---------|------------------|---|-------------------|---------------------|---|--|--|------------------------------------|--|--|--|--|-------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. DATE KNOWN OF DEATH | | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | | |
| Flora I. McRae | | | 1/16 1979 | | | 1/16 1979 | | | 1/16 1979 | | | 3:14 A.M. | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | | | | | | | | | | |
| Female | White | Nov. 16, 1899 | 79 YRS. | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 7c. MARRIED | | | 7d. NEVER MARRIED | | | 7e. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| New York | | | USA | | | WIDOWED | | | DIVORCED | | | Montgomery County MD | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Silver Spring | | | 8505 Springvale Road | | | Housewife | | | own home | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | |
| Maryland | | | Montgomery | | | Silver Spring | | | YES XX NO | | | 8505 Springvale Road | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | |
| Melvin Waldren | | | Grace Barlow | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | | | | | |
| no | | | none | | | 215-60-7672 | | | Jane Grasso-dau-Tappan, N.Y. 10983 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute myocardial disease. | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | | | | |
| None | | | | | | | | | YES NO XX | | | | | | |
| 21a. EXTERNAL CAUSE WAS | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | P.M. 19 | | | None | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION | | | CITY OR TOWN | | | COUNTY | | STATE | |
| WHILE AT WORK NOT WHILE AT WORK | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | | | | | | | | |
| John S. Rogers, M.D. | | | Deputy | | | 1/16/79 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | | | | | | | | |
| John S. Rogers, M.D. | | | Silver Spring, Montgomery, Md. | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIUM | | | 23d. LOCATION | | | | | | |
| Burial | | | Jan. 19-79 | | | Tappan Reform Cemetery | | | Tappan New York | | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Wagner E. Pumphrey, Inc. | | | JAN 15 1979 | | | Clark E. Wilson | | | | | | | | | |
| 8434 Ga. Ave., S.S. Md. | | | | | | | | | | | | | | | |

00150-01

100% NOTION
11/18/14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-02101 | |
|---|--|--|--|--|--|---|----------------------------|--|--|-------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARY IRENE MEILE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1 5 79 | | | 2b. HOUR
3:05 AM | | | |
| 3 SEX
Female | | 4 RACE
Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR
July 13 1894 | | 6 AGE (IN YEARS LAST BIRTHDAY)
84 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., DC | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
9118- Sudbury Rd. | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
(Unknown) | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
(Unknown) | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- | | 17 INFORMANT
Mrs. Janis L. Brittain- above address
(Niece) | | ADDRESS | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RENAL INSUFFICIENCY</u>
4409
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ARTERIO SCLEROTIC VASCULAR DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>METASTATIC SQUAMOUS CELL CA SCALP.</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>METASTATIC SQUAMOUS CELL CA SCALP.</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>72</u> , to <u>January</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>January 5</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Bernard A. Fitzgerald MD</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-5-79 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BERNARD A. FITZGERALD | | | | | 22e. ADDRESS
217 UNIVERSITY BLVD E. SILVER SPRING, MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/8/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pr. Geo. Md. | | | | | |
| 24 FUNERAL DIRECTOR NAME
Nalley's F.H. Inc. | | ADDRESS
Mt. Rainier, Md. | | 25a. DATE REC'D BY REGISTRAR
1-8-79 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | |

10150-02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02102
REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|--|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
Edward MATHIAS Meyers SR | | 2a. DATE OF DEATH
MONTH DAY YEAR
JANUARY 15, 1979 | | 2b. HOUR
3:50 | |
| 3. SEX
Male | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
3 23 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Montgomery Co. Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING YEARS)
National Sales Representative | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
MD. | | 13c. CITY OR TOWN
Takoma Park | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
7410 MAPLE AVENUE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Emil Mathias Meyers Theresia Serie | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Theresia Serie | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO
578-15-4292 | | 17. INFORMANT
Jeanette T. Meyers Wife | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 MINUTES |
| DUE TO, OR AS A CONSEQUENCE OF
(b) MYOCARDIAL INFARCTION, ACUTE, ANTERIOR | | 30 HRS. |
| DUE TO, OR AS A CONSEQUENCE OF
(c) CORONARY ARTERY DISEASE | | 20 YEARS |

| | | | | | |
|---|--|--|--|--------------------------|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
CONGESTIVE HEART FAILURE | | | | DIABETES MELLITUS | |
| 19a. DATE OF OPERATION
- | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

| | |
|--|--|
| 22. I certify that (1) (this hospital) attended the deceased from JAN 23, 1956 , to JAN 15, 1979 , that (H) (we) lost saw the deceased alive on JAN 15, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (we) (did) (did not) view the body after death. | |
| 22b. SIGNATURE
James A. Roberts, M.D. | 22c. DATE SIGNED
JAN 15, 1979 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES A. ROBERTS | 22e. ADDRESS
8907 GEORGIA AVE SILVER SPRING, MD. |

| | | | |
|--|---|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
JAN. 17-1979 | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
Silver Spring Mont. Co. Md. |
| 24. FUNERAL DIRECTOR
(NAME)
John F.H. (J.A.) WATERS | 24b. ADDRESS
254 CARROLL ST. NW Wash., D.C. 20012 | 25a. DATE REC'D. BY REGISTRAR
JAN 22 1979 | 25b. REGISTRAR'S SIGNATURE
Anthony McCreedy |

18-05105

18-05105

18-05105

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
|--|---|---|--------|--|---|---|--|------------------|--|
| Lazar Mihajlovich | | | | | January | 13 | 1979 | | 1 P M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | | |
| Male | white | 3 17 93 | | 85 YRS | MONTHS | | DAYS | | HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Yugoslavian | USA | | | Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Silver Spring | Holy Cross Hospital | | | Retired | Director of Security | | | | |
| 13a. STATE | | | | 13b. CITY OR TOWN | 13c. STREET ADDRESS | | | | |
| MARYLAND | | | | MONTGOMERY | Silver Spring | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Mihajlo | | | | Ivana | | Jankovic (unknown) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| no | | | | none | | 169-26-2524 Dusan Mihajlovich-son-(same as 13e) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac sudden collapse - secondary</u>
5188
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>to acute pulmonary infection</u>
(c) <u>and myocardial drainage</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> , 19 <u>78</u> , to <u>1/13</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1/12</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | |
| Joseph M. Solinas | | | | MD | | | | 1/14/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| Joseph Solinas, MD | | | | 9801 Ga. Avenue, Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | Jan. 17-79 | | Rock Creek | | Washington, DC | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Warner E. Pumphrey, Inc. | | | | JAN 15 1979 | | [Signature] | | | |
| 8434 Ga. Ave., S.S. Md. | | | | | | | | | |

18-05103

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Classed with medical examiner Dr. Rogers by phone.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

79-02104

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEASED-NAME (Type or print) Edward Chester Millen | | | 2a. DATE OF DEATH
Month January Day 12 Year 1979 | | | 2b. HOUR 6 A M | |
| 3. SEX Male | | 4. RACE white | | 5. DATE OF BIRTH
Sept 29, 1907 | | 6. AGE (In years last birthday)
71 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 9711 Brixton Lane | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Optician | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) STATE MD | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Bethesda | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First Edward Middle Colvin Last Millen | | 15. MOTHER'S MAIDEN NAME First Mary Middle Eliza Last Martin | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | | |
| 16b. SOCIAL SECURITY NO. 411-09-1253 | | 17. INFORMANT Helen J. Millen Address Wife - same as deceased. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4149 Coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a). Atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
stating the underlying cause last. many year
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 years |
| 19a. DATE OF OPERATION none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED none | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) none | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec , 19 61 , to Nov 21 , 19 78 , that (I) (we) last saw the deceased alive on Nov 21 , 19 78 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Allen J. O'Neill MD | | DEGREE MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED Jan 12, 1979 | |
| 22d. PHYSICIAN'S NAME (Type) Allen J. O'Neill | | 22e. ADDRESS 8601 Old George town Rd. Bethesda MD | | | | | |
| 23a. BURIAL, CREMATION, REINTERMENT (Specify) | | 23b. DATE JAN. 15 1979 | | 23c. NAME OF CEMETERY OR CREMATORY MT OLIVE | | 23d. LOCATION (City or Town) (County) (State) MT. OLIVE NC | |
| 24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS INC. | | ADDRESS 5130 WISC AVE. NW. WASHINGTON DC | | 25a. REC'D BY REGISTRAR JAN 18 1979 | | 25b. REGISTRAR'S SIGNATURE Henry McCreedy | |

40150-82

2002 年 10 月 10 日

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505

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 79-02105
REG. NO. | |
|---|--|----------------------|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Margaret M. Miller | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 1/19/ 1979 | | 2b. HOUR 7:15 | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH
MONTH 2 DAY 25 YEAR 1913 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 65 YRS. | | 7. IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0 | | 2c. DATE PRONOUNCED DEAD 1/19/ 1979 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY Clothing | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13a. STATE MD | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN CHEVY CHASE | |
| 14. FATHER'S NAME
FIRST Robert MIDDLE Miller LAST Miller | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Nellie MIDDLE Havener LAST Havener | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Dorothy Fagan, Executrix.. | | | | | | 17. ADDRESS Blvd. Chevy Chase | | 17. ADDRESS 5500 Friendship | | 17. ADDRESS 5500 Friendship | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS
DUE TO, OR AS A CONSEQUENCE OF
(b) CORONARY ARTERIOSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) HYPERTENSIVE CARDIOVASCULAR DISEASE | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2-4 hrs
3-4 yrs
10 + yrs | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 2-3 P.M. 1 19 1979 | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR 2-3 P.M. 1 19 1979 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) IN BED AT HOME | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME | | | | 21f. LOCATION
STREET 5300 FRIENDSHIP BLVD CITY OR TOWN CHEVY CHASE COUNTY MT. STATE MD | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Francis C. Mayle Jr. | | | | TITLE (SPECIFY) Dept | | | | DATE SIGNED 1/20/79 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle Jr. | | | | ADDRESS 5200 Wisconsin Ave Bethesda MD 20014 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE 1/23/1979 | | | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | | |
| 23d. LOCATION
CITY OR TOWN Suitland, Maryland | | | | COUNTY Montgomery | | | | STATE MD | | | |
| 24. FUNERAL DIRECTOR
NAME JOSEPH GAWLER'S SONS INC. | | | | ADDRESS 5130 WISC. AVE., N. W. WASH., D. C. 20016 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1979 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE Dorothy Fagan | | | |

72-05102

1992-1993

Released by Dr. BALL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02106
REG. NO. | |
|---|--|--|--|---|--|---|--|--|--|----------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Mary Jane Mills | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1/30/79 | | | 2b. HOUR
9:45 P M | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 22 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
None | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
408 HORNERS LANE | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harvey Brooks Kinder | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Ellen Thompson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-32-9783 | | 17. INFORMANT ADDRESS
Gary W. Mills (same as 13e) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac Arrest - arrhythmic</i>
4148
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Chronic Coronary Thrombosis</i>
(c) <i>Arteriosclerotic Cardiovascular Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15'
5 yrs
5 yrs | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>Atrial Fibrillation, agitated chronic Bronchitis</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/2/1957</i> to <i>1/30/1979</i> , that (I) (we) last saw the deceased alive on <i>1/27/1979</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Stephen N. Jones</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/30/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Stephen N. Jones | | | | 22e. ADDRESS
809 VIERS MILL RD., ROCKVILLE, MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
2-2-79 | | 23c. NAME OF CEMETERY OR CREMATORY
FOREST OAK CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
GAITHERSBURG MONTG. MD. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT A. PUMPHREY FUNERAL HOMES P/A | | | | ADDRESS
ROCKVILLE MD. | | 25a. DATE REC'D. BY REGISTRAR
FEB 7 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>Robert A. Pumphrey</i> | | | |

24. FUNERAL DIRECTOR

NAME

ADDRESS

ROCKVILLE

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

7a-05106

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02107 | |
|--|--|--|--|---|--|--|---|--|--|----------|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Anthony M. MINUTOLO | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
January 10 1979 | | | 2b. HOUR
3:58 P M | | | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR
August 17 1936 | | 6 AGE (IN YEARS LAST BIRTHDAY)
42 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Naval Medical Center | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
U. S. Marine Corps | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE 13b COUNTY 13c CITY OR TOWN
Virginia Stafford Falmouth | | | | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS
Route 5, Box 283 | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Frank Minutolo | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Pauline Sandy | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
1955-75 | | 17 INFORMANT ADDRESS
Mrs. Edith Minutolo See item 13 | | | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissiminated gastric carcinoma; inferior vena cava</u>
1519
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>January 5</u> , 19 <u>79</u> , to <u>January 10</u> , 19 <u>79</u> , that (1) (we) lost <u>saw the deceased alive on January 10, 1979</u> , and that in (my, our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE
<u>Michael D. Mahoney</u> | | | | DEGREE
<u>MD</u>
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED
Jan. 11, 1979 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael D. Mahoney, M. D. | | | | 22e ADDRESS
National Naval Medical Center, Bethesda, Md. | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 15, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Va. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wheeler and Thompson Funeral Home Fredericks- | | | | 25. DATE REC'D. BY REGISTRAR
JAN 10 1979 | | 25b REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | |

BP

19-02107

January 10 1975 3:30 P

MINUTOLO

January

42

August 17 1936

Concession

Male

Montgomery

1936

New York

U. S. Marine Corps

National Naval Medical Center

Bethesda

Route 2, Box 282

x

Stafford Bethesda

Virginia

Bundy

Pauline

Minutolo

Frank

1952-53 115 20 1957 Mrs. Edith Minutolo See item 13

Yes

isolated gastric carcinoma; inferior vena cava

x

x

January 10 75

January 10 75

75

January 5 75

75

January 10 75

75

75

Jan. 11, 1975

x

National Naval Medical Center, Bethesda, Md.

Michael D. Hanchey, I. D.

Arlington Arlington Va.

Arlington National

Jan. 15, 1975

Gertrude

burg, Va.

Wheeler and Thompson Funeral Home and Embalmer

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-02108

| | | | | | |
|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | MONTH DAY YEAR | |
| Edith Bell Mitchell | | January 5, 1979 | | 7:00 M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | |
| Female | Caucasian | MONTH DAY YEAR | IF UNDER 1 YEAR | | |
| | | May 6 1884 | MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| North Dakota | USA | | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Rockville | Collingswood Nursing Center | | Retired | | U.S. Gov't |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. CITY OR TOWN | 13b. INSIDE CITY LIMITS? | 13c. STREET ADDRESS | |
| 13a. STATE 13b. COUNTY Maryland Montgomery | | Rockville | YES <input type="checkbox"/> NO <input type="checkbox"/> | 16421 Grande Vista Drive | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| William Bell | | Charlotte McDonald | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 4542-20-1625 | | Rockville, Md. 20855 | |
| | | Mary E. White | | 16421 Grande Vista Dr. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <i>Cardio Respiratory Collapse</i> | | | | | |
| 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Artery Disease + Emphysema</i> | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 75 to Jan 5 1979, that (I) (we) last saw the deceased alive on Dec 5 1978, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Robert T. Thibadeau | | | | 1-5-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Robert T. Thibadeau, M.D. | | 11125 Rockville Pike #103 Rockville, Md. 20852 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN |
| Cremation | | 1/6/79 | Cedar Hill Crematory | | Prince George's Co. |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Murphy F.H.-Falls Church, 1102 W. Broad St., Falls Church, Va. | | JAN 9 1979 | | History McCreedy | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

80150-01

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02109

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Ora A. Mitchell | | | 2a DATE OF DEATH
MONTH DAY YEAR
Jan. 25 1979 | | | 2b HOUR
4:00P M | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 8, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ill. | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Chevy Chase Nursing & Convalescent Ctr. | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Auditor | | 12b. KIND OF BUSINESS OR INDUSTRY
Railroad | |
| 13a STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1111 W. University Blvd. | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Allen C. Mitchell | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
Unknown | | 17 INFORMANT
ADDRESS
Charles Williams 740 - 15th St. N.W. Wash. D.C. | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Staphylococcal Sepsis
0381
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 Month | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Organic brain syndrome | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1978, to Jan 25, 1979, that (I) (we) last saw the deceased alive on Jan 23, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE
Debra B Goldberg MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/25/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DEBORAH B GOLDBERG | | | | 22e. ADDRESS
1106 Spring St, Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/29/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood, Md. | | | |
| 24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.
NAME ADDRESS
5130 Wisc. Ave. N.W. Wash., D.C. | | | | 25a. DATE REC'D BY REGISTRAR
JAN 31 1979 | | 25b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

73-05103

1910 Inc. vs. W. W. Webb, Jr.
Joseph L. Lister & Son, Inc.
W. S. Lincoln & Son, Inc.
Franklin, Inc.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-02110

| | | | | | |
|---|--|---|--|---|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | P M | |
| Dwight Chapin Monnier | | January 22, 1979 | | 3:15 | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Male | White | MONTH DAY YEAR | 60 YRS | IF UNDER 24 HRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| Conn. | USA | | Montgomery County, MD. | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY |
| Bethesda | NIH Clinical Center, Bethesda, Md. | | Health Administrator | | |
| 13a STATE | | 13b COUNTY | 13c CITY OR TOWN | 13d INSIDE CITY LIMITS? | 13e STREET ADDRESS |
| Maryland | | Montgomery | Damascus | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 26401 Cornor Dr. 20750 |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | ADDRESS | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| William Darling Monnier | | Maude Nottingham | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | 17 INFORMANT | | |
| Yes | | W.W. 2 | Mrs. Lorraine Monnier (same as above) | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Renal Failure | | | | | 1 Week |
| 1889 DUE TO, OR AS A CONSEQUENCE OF (b) Bladder Cancer | | | | | 4 Years |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| (L) Retroperitoneal Abscess | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| January 18, 79 | | Retroperitoneal Abscess | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a I certify that (we) this hospital) attended the deceased from December 18, 1978, to January 22, 1979, that X (we) lost saw the deceased alive on Jan. 22, 1979, and that (we) (our) opinion death occurred on the date and hour and from the causes stated above. X (we) did not view the body after death. | | | | | |
| 22b SIGNATURE | | DEGREE | | 22c DATE SIGNED | |
| | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 01/23/79 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | |
| Dr. Sandra Foote, MD | | National Institutes of Health Clinical Center, Bethesda Md. 20014 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE |
| Burial | | Jan. 27, 1979 | East Lawn | | East Haven, Connecticut |
| 24 FUNERAL DIRECTOR NAME | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| Olin L. Molesworth, Damascus, Md. | | JAN 26 1979 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 79-02111 | | | |
|--|--|--|--|---|--|---|---|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Mary Louella Moore | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1-6-79 | | 2b. HOUR
10:00 P.M. | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
2 8 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
73 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wash. Adventist Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Clerk - Storage Co. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Pr. Geo. | | 13c. CITY OR TOWN
W. Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
George Dickinson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Etna L. Boyd | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
578-01-7610 | | 17. INFORMANT ADDRESS
Peggy T. Lasky - above address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) <u>Renal Failure</u> (Dtr.)
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma of Colon</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>1539</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 year</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>15 Aug 19 77</u> to <u>6 Jan 19 79</u> , that (I) (we) last saw the deceased alive on <u>6 Jan 19 79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Thomas A. Bennington MD | | | | DEGREE
MD | | 22c. DATE SIGNED
7 JAN 79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THOMAS A. BENNINGTON MD | | | | 22e. ADDRESS
831 University Blvd E. S. 1 Sq. Md 20803 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/9/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Brentwood Pr. Geo. Md. | |
| 24. FUNERAL DIRECTOR NAME
Nalley's F.H. Inc. | | | | ADDRESS
Mt. Rainier, Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 11 1979 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

99

5801 BP

11110211

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-02112

| | | | | | | | | |
|--|-------------------------|---|---|---|---|--|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) Michael Moore | | | 20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 1-29 1979 | | | 21. HOUR 10¹⁰ AM | | |
| 3. SEX
M | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR 7-5-57 | 6. AGE (IN YEARS)
LAST BIRTHDAY MONTHS DAYS HOURS MIN. 21 YRS. | IF UNDER 1 YR. | IF UNDER 24 HRS. | 22. DATE PRONOUNCED DEAD Jan 29 1979 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Tenn. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
4216 Independence Street | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Leonard Lee Moore | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Frances Laudean White | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO.
1976 | | 17. INFORMANT
Leonard Lee Moore ADDRESS
4216 Independence St. Rockville, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gun Shot Wound of Abdomen -
9552
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) Self-Inflicted
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR AM MONTH DAY YEAR
P.M. 1-24 1979 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Shot Self in abdomen with 22cal Rifle | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
4216 Independence St. Rockville Montgomery Md | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
John G. Ball | | | TITLE (SPECIFY)
Deputy | | | DATE SIGNED
Jan 29 1979 | | |
| EXAMINER'S NAME
(TYPE OR PRINT) John G. Ball | | | ADDRESS 7936 Old Georgetown Rd. Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Feb. 1, 79 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Virginia | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hines/Rinaldi 11800 New Hampshire Sil. Spg. Md. | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 1 1979 | | 25b. REGISTRAR'S SIGNATURE
Anthony McCreedy | |

18-05115

489 (837

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified, avenge.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02113
REG. NO.

| | | | | | | | | | |
|--|--|---|---|--|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) MARY F MORAN | | | 2a. DATE OF DEATH MONTH 1 DAY 15 YEAR 79 | | | 2b. HOUR 8:15 M | | | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5 DATE OF BIRTH MONTH 2 DAY 22 YEAR 04 | | 6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., DC | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10 CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY own home | |

| | | | | | | | | |
|---|--|--|--|--|--|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13b. STREET ADDRESS 8304 16th. Street, | | |
| 13a. STATE Maryland | | | 13b. COUNTY Montgomery | | | 13c. CITY OR TOWN Sil. Spring | | |
| 14. FATHER'S NAME FIRST George MIDDLE DIXON LAST DIXON | | | 15. MOTHER'S MAIDEN NAME FIRST Dorothy MIDDLE Chaconas LAST (unknown) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. 578--12-4427 | | | 17. INFORMANT ADDRESS Lawrence F. Moran-husband-(same as 13c) | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) cerebral hemorrhage | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| 431-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis | | 2 years | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | |

| | | | |
|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) diverticulitis with obliterant cholangitis, Arthritis Cardiovascular | | | |
| 19a. DATE OF OPERATION none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED none | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-17- 19 75 , to 1-15 19 79 , that (I) (we) lost show the deceased alive on 1-15 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE James H. Scully | | 22c. DATE SIGNED 1-16-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES H. SCULLY | | 22e. ADDRESS 5530 Wisc Ave Chevy Chase Md 20015 | |

| | | | | | | | |
|--|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan 19 1979 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spr. Montgomery Md. | |
| 24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc ADDRESS 8434 Ga. Ave., S.S. Md. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1979 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

13-05113

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02114
REG. NO. | | | |
|--|--|---|--|---|---|--|---------------------------------------|---|--|--|--|--------------------------------|--|
| 1. FOR STATE REGISTRAR
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
JEAN K. MORGAN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
Jan. 9, 1979 | | | 2b. HOUR
5 A.M. | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Nov. 1, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Althea Woodland of Sil. Spg. N.H. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
At Home | | | | | |
| 13a. STATE
Md. | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Ft. Sumner Hills | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Frank - Kearns | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lee - Carroll | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
182-01-9037 | | 17. INFORMANT
Mrs. Constance Zahn | | ADDRESS
5236 Westpath Way
Ft. Sumner Hills, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Papillary Cancer of the breast</i>
1749
DUE TO, OR AS A CONSEQUENCE OF (b) <i>with extreme metastasis</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6/1/75</i> to <i>1/9/79</i> , that (I) (we) last saw the deceased alive on <i>12/31/78</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE <i>Frank Kleh</i> DEGREE | | 22c. DATE SIGNED <i>1/9/79</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jack Kleh, M.D. | | | | 22e. ADDRESS
1145 - 19th St. N.W. Wash., D.C. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 11, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Glenwood Mem. Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Broomall Del. Penn. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME
JOSEPH CAWLER'S SONS INC.
5130 WISG. AVE., N.W. WASH. D.C. 20018 | | | | 25a. DATE RECORDED BY REGISTRAR 75b. REGISTRAR'S SIGNATURE
<i>John C. Smith</i> | | | | | | | | | |

41150-05



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified of course.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-02115 | |
|--|--|---|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Albert - Munson | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan. 17, 1979 | | | 2b. HOUR
330 P.M. | | | |
| 3 SEX
male | | 4 RACE
WHITE | | 5 DATE OF BIRTH
MONTH DAY YEAR
JAN. 20 1891 | | 6 AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SINGAPORE, MA. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD | | | | | |
| 10 CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ORDAINED MINISTER | | 12b. KIND OF BUSINESS OR INDUSTRY
(RET) | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2848 SHANNONDALE DRIVE | | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
R. W. MUNSON | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CARRIE LOUISE GASSER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
566-50-9584 | | 17. INFORMANT
ADDRESS
DAVID H. BAASCH - 2848 SHANNONDALE DR | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Respiratory Failure
5070 DUE TO, OR AS A CONSEQUENCE OF
(b) Aspiration Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) Urinary Tract Infection
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr
10 days | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1/15 , 19 79 , to 1/17 , 19 79 , that (I) (we) lost
saw the deceased alive on 1/17 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Alfred Munzer M.D. | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Jan. 17, 1979 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Alfred Munzer M.D. | | 22e. ADDRESS
7600 Carroll Ave Takoma Park Ma. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Jan. 19, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
East Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore P.D. MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
J.A. Walters, Takoma F.H. Inc. | | ADDRESS
Washington, D.C. 20012 | | 25a. DATE REC'D. BY REGISTRAR
JAN 22 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

12-05112

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02116 | | | | |
|--|--|---|--|---|--|--|----------------------------------|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Kitty T. MYAING | | | | | 2a. DATE OF DEATH
MONTH 1 DAY 19 YEAR 79 | | | | | 2b. HOUR
6:22 P. M. | | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH July DAY 9 YEAR 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 1 YRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Burma | | 7b. CITIZEN OF WHAT COUNTRY?
Burma | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
364 N. Summit Ave. | |
| 14. FATHER'S NAME
FIRST Gopal MIDDLE LAST Singh | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Daw MIDDLE LAST AI | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
no | | 17. INFORMANT
ADDRESS
Robert Myaing same as 13e | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
1629
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Suspected Pneumonia and
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) Small Cell Lung Cancer | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
hours
days
months | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.
Pseudomonas and Salmonella Infections - Malnutrition | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1/13 19 79 , to 1/19 19 79 , that (I) (we) last saw the deceased alive on 1/19 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Stephen J. Newman | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED
1/20/79 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephen J. Newman | | | | | 22e. ADDRESS
Montgomery Village Ave. Gaithersburg, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
1/23/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery Silver Spring, Md. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Tyson Wheeler Funeral Home, Inc. | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 24 1979 | | | 25b. REGISTRAR'S SIGNATURE
Robert Myaing | | | | | | |
| 1331 Rockville Pike Rockville, Md. 20852 | | | | | | | | | | | | | | |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02117

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | |
|---|----------------------------------|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Charles Edwin Nance | | 2a. DATE OF DEATH
MONTH DAY YEAR
01 22 79 | | 2b. HOUR
4:15AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
11 14 1886 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 |
| 7a. CITY OR TOWN OF DEATH
Charles City Co. Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery | | MD. | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery Gen. Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Farmer |
| 12b. KIND OF BUSINESS OR INDUSTRY
Agriculture | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | |
| 13a. STATE
Md. | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
15521 Prince Frederick Way |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Stagg Nance | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sally Major Nance | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
231-62-9509 | | 17. INFORMANT
ADDRESS
Mrs. Charlotte N. Saylor (daug.) |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
4039
DUE TO, OR AS A CONSEQUENCE OF
(b) chronic nephrosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) unknown. | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
10 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Aneurysm | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from 18 January 1979 to 22 January 1979 that (I) (we) last saw the deceased alive on 21 Jan 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | |
| 22b. SIGNATURE
Harold I. Passes | DEGREE
Attending Physician | 22c. DATE SIGNED
22 Jan 79 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Harold I. Passes, M.D. | 22e. ADDRESS
4425 Montgomery Ave., Beth., Md. 20011 | |

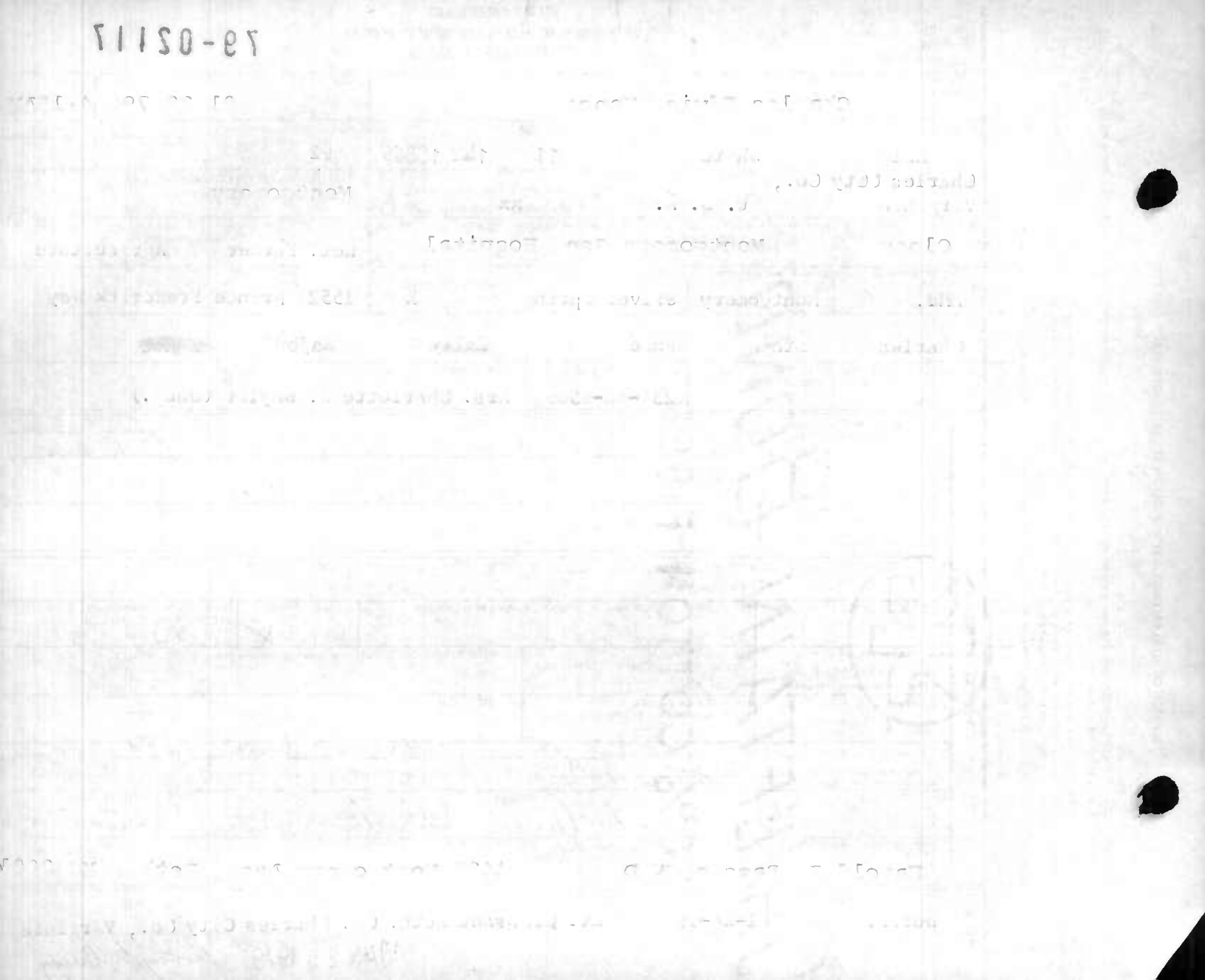
| | | | |
|---|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
1-24-79 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Pleasant Meth. Ch. Charles City Co., Virginia | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR
NAME
John J. Macgregor | | 25a. DATE REC'D. BY REGISTRAR
JAN 25 1979 | |
| ADDRESS
Richmond VA #26 | | 25b. REGISTRAR'S SIGNATURE
Patrick McCreedy | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

78-05117



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-02118 | |
|--|--|---|---|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) James B Newton | | | 2a. DATE OF DEATH
MONTH JAN DAY 16 YEAR 1979 | | | 2b. HOUR
6:50 P.M. | | | | | |
| 3 SEX
MALE | | 4 RACE
NEGRO | | 5 DATE OF BIRTH
MONTH JAN DAY 9 YEAR 1890 | | 6 AGE (IN YEARS LAST BIRTHDAY)
89 YRS | | 7 UNDER 1 YEAR
MONTHS DAYS | | 7 UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SOUTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
COAL MINER | | 12b. KIND OF BUSINESS OR INDUSTRY
 | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Hyattsville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1001 Chatham Road | | | |
| 14 FATHER'S NAME
FIRST Unknown MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST Unknown MIDDLE LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
209-09-3959 | | 17 INFORMANT
Myretta Gladman | | ADDRESS 1001 Chatham Road Hyattsville, MD. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 WEEK | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
 P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from NOV 19 1978 to JAN 16 19 79 , that (I) (we) saw the deceased alive on JAN 16 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Walter E. Goode | | | | | | DEGREE
MD | | 22c. DATE SIGNED
12 JAN 1979 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALTER E. GOODE MD | | | | | | 22e. ADDRESS
2309 SHOREFIELD RD WHEATON MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
1-20-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Benny Gurck | | | 23d. LOCATION
CITY OR TOWN MARLBORO COUNTY B. Carolina STATE | | | |
| 24 FUNERAL DIRECTOR
NAME LEON THORNTON ADDRESS R.R. 1 Box 115 THORNTON Funeral Home Pomonkey, MD. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 25 1979 | | 25b. REGISTRAR'S SIGNATURE
Henry McCreedy | | | |

18-05118

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02119
REG. NO. | |
|--|--|---|--|---|--|--|--|---|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) John J. Nietmann, Jr. | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
Jan. 12, 1979 | | 2b. HOUR
5:00 AM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 14 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4928 Sentinel Drive | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
General Counsel | | 12b. KIND OF BUSINESS OR INDUSTRY
Trade Assoc. | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4928 Sentinel Drive | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John J. Nietmann | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Theresa Crilly | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
092-10-2966A | | 17. INFORMANT
ADDRESS
Ethel A. Nietmann - Wife Bethesda, Md. | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY
185- Cancer of the prostate
IMMEDIATE CAUSE (a) With spread metastases
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/12/79 to 1/12/79 , that (I) (we) last saw the deceased alive on 1/12/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Mark Immergut MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/12/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARK Immergut | | | | 22e. ADDRESS
10401 Old Georgetown Rd Suitland, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | | 23b. DATE
1/13/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph Gawler's Sons, Inc.
5130 Wisc. Ave. N.W. Wash., D.C. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 18 1979 | | 25b. REGISTRAR'S SIGNATURE
John J. McCreedy | | | |

72-05118

79-02120

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may also be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-02120 | |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Alice W. OATES | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
January-21 1979 | | 2b. HOUR
4:45 A.M. | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
Oct. 19 th , 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Connecticut | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Colonial Villa. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Pub. Schools | | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5 Derbyshire Court | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Michael O'Neil | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Elizabeth O'Toole | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
047-30-2010 | | 17. INFORMANT ADDRESS
Elizabeth M. Marcotte, Same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Upper respiratory infection</u>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>Chronic brain syndrome</u>
(c) <u>Cerebral arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
4370
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>Coronary heart disease</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 wks
Years
Years | |
| 19a. DATE OF OPERATION
2/9 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/2/77</u> to <u>1/21/79</u> , that (I) (we) last saw the deceased alive on <u>1/18/79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
George Skenton MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/21/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GEORGE S. KENTON | | | | | | 22e. ADDRESS
10620 GEORGIA AVENUE, S.S., Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/24/79 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Bernard's Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Connecticut | | | | | |
| 24. FUNERAL DIRECTOR NAME
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 24 1979 | | 25b. REGISTRAR'S SIGNATURE
Ruthy McBratney | | | |

BP

13-05150



JAN 1919

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02121
REG. NO.1 - FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|--|--|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
THOMAS JAMES O'CONNELL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan. 22 1979 | | 2b. HOUR
5:00AM | | | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
Feb. 21 1925 | | 6 AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
53 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Colorado | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | |
| 10 CITY OR TOWN OF DEATH
Kensington | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
10225 Kensington Parkway | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Attorney | | 12b. KIND OF BUSINESS OR INDUSTRY
Federal Reserve Board | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Kensington | | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
10225 Kensington Parkway | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Patrick O'Connell | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Winfred Collins | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17 INFORMANT
Son | | ADDRESS
Wash. D.C. | | |
| | | 579-12-2825 | | Kevin J. O'Connell | | 4564 MacArthur Blvd., N. | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest (sudden death) | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
— | |
| 2500 } DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic cardiovascular disease | | | | | | | 6 years | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Insulin dependent diabetes | | | | | | | 27 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
Cerebrovascular disease with ischemic optic Neuropathy | | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/21 , 19 76 , to 11/22 , 19 79 , that (I) (we) last
saw the deceased alive on 11/3 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Robert L. Flynn M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Jan. 22, 1979 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert L. Flynn M.D. | | | | 22e. ADDRESS
5454 Wisconsin Av. Chevy Chase Md. 20015 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/24/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | |
| 24. FUNERAL DIRECTOR
NAME
JOSEPH GAWLER'S SONS INC.
ADDRESS
5130 WISC. AVE., N. W. WASH., D. C. 20016 | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 29 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |

The medical examiner must be notified within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified within 72 hours after death.

12-05151

12-05151

12-05151

12-05151

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 7/77
(VR A 15 (4))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02122
REG. NO. | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|----------|--|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH | | | | | MONTH DAY YEAR | | 2b. HOUR | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | | FIRST MIDDLE LAST | | | | | 1-28-79 3 ³⁰ P M | | | | |
| 3 SEX | | | | | 4 RACE | | | | | 5. DATE OF BIRTH | | | | |
| Female | | | | | White | | | | | MONTH DAY YEAR JAN - 05 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | |
| INDIANA | | | | | U.S.A. | | | | | 74 YRS. MONTHS DAYS HOURS MIN. | | | | |
| 10 CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Takoma PK. | | | | | Washington Adventist Hosp. | | | | | Montgomery County MD. | | | | |
| 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | 13a. STREET ADDRESS | | | | |
| Secretary | | | | | Sec. Conf. | | | | | 8301-Greenwood Ave. | | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | | | | 13b. CITY OR TOWN | | | | |
| Henry B. Ogile | | | | | Kellie Hartless | | | | | YES NO | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT (NAME AND ADDRESS) | | | | |
| No | | | | | 578-50-5491 | | | | | Keith Walkings (13e) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | MAY 07 1979 | | | | |
| 410- Cardiac Shock - by state | | | | | | | | | | 1 week | | | | |
| DUE TO OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | | |
| Acute Myocardial Infarction | | | | | | | | | | | | | | |
| DUE TO OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | |
| Coronary atherosclerosis | | | | | | | | | | Years | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | YES NO | | YES NO | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2) | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| | | | | | | | | 38 79 | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/28/79 to 1/28/79, that (I) (we) lost saw the deceased alive on 1/28/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | DEGREE | | 22c. DATE SIGNED | | | | |
| Samuel L. Scott | | | | | | | | MD | | 1/28/79 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN | | | | | | |
| SAMUEL L. SCOTT | | | | | | | | DIRECTOR | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | |
| Burial | | | | | | | | Feb. 1, 1979 | | Rocust Grove Cemetery | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | 24b. ADDRESS | | 25. DATE REC'D. BY REGISTRAR | | | | |
| Keith Walkings | | | | | | | | 254 Carroll St. NW | | FEB 1 1979 | | | | |
| 25a. REGISTRAR'S SIGNATURE | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

12-05155

47

20-10-02

11-11-02

11-11-02

11-11-02

11-11-02 11-11-02 11-11-02

11-11-02 11-11-02 11-11-02

Dr. Ball released to Dr. Traum

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02123
REG. NO. | |
|---|--|--|--|---|--|---|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Mildred LOVETTA Oland | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 - 1 - 79 | | | 2b. HOUR
8:25 P.M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 5, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
H. Wife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Mt. Airy | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John T. Patton | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lola - McKinney | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-24-2835 | | 17. INFORMANT ADDRESS
M. A. Oland Same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4415 INTOL A ABDOMINAL HEMMORRAGE
DUE TO, OR AS A CONSEQUENCE OF (b) RUPTURED AORTIC ANEURYSM
DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROSIS | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 DAYS
SAME
UNKN. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
MARKED EMPHYSEMA | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 3, 1974, to January 1, 1979, that (I) (we) lost saw the deceased alive on January 1, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Aaron H. Traum MD | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
January 2 1979 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
AARON H. TRAUM MD | | | | | 22e. ADDRESS
8915 Georgia Ave Silver Spring Md 20910 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Jan. 5, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Frederick Frederick Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Francis H. Barber | | | | | ADDRESS
Laytonsville, Md. 20760 | | 25a. DATE REC'D. BY REGISTRAR
JAN 8 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

38-05153



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02124
REG. NO. | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>EUGENIA I. OLIFF</i> | | | | January 22, 1979 | | | | 5 P M | | | |
| 3 SEX
Female | | 4 RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
March 2, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Potomac Valley Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Virginia | | 13b. COUNTY | | 13c. CITY OR TOWN
Colonial Bch. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1012 Marshall Avenue | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Frank Dodd | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary E. Marks | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
N/A | | 17 INFORMANT ADDRESS
Arlington, VA. | | Son-Carroll Oliff, 5550 Columbia Pike, | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Renal Failure</i>
226-
DUE TO, OR AS A CONSEQUENCE OF (b) <i>CEREBROVASCULAR ACCIDENT</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Papillary Adenoma Thyroid - Metastasis</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>FEBRUARY 10 1978</i> to <i>JANUARY 22 1979</i> , that (I) (we) last saw the deceased alive on <i>January 22 1979</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>M. R. Cascard</i> | | | | DEGREE
M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/22/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MIGUEL R CASCARDO | | | | 22e. ADDRESS
12400 BOBINIK CT
POTOMAC, Maryland 20854 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
1/25/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Oakwood Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Falls Church, Virginia | | | |
| 24 FUNERAL DIRECTOR NAME
Ives Funeral Home, 2847 Wilson Blvd., Arl., VA. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 20 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>L. J. McCreedy</i> | | | |

12-05154

12/

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02125

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 3. SEX | | 4. RACE | |
| FIRST MIDDLE LAST
Abraham (N) Orden | | male | | Caucasian | |
| 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| MONTH DAY YEAR
Oct. 15, 1892 | | 86 YRS | | Montgomery MD | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Russia | | U.S.A. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Silver Spring | | Holy Cross | | Projectionist | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS | | 13b. INSIDE CITY LIMITS? | |
| Motion Picture | | 3607 Stewart Drive | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | |
| FIRST MIDDLE LAST
Unknown | | FIRST MIDDLE LAST
Unknown | | No | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | |
| 073-09-0856 | | Sol Orden (Son) | | PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypokalemia
DUE TO, OR AS A CONSEQUENCE OF
(b) renal failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerotic cardiovascular disease | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| 12-26-78 | | Benign prostatic hypertrophy | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 1972 to 1-1 1979, that (I) (we) last saw the deceased alive on 1-1 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | 22b. SIGNATURE
Jason Greiger, M.D. | | 22c. DATE SIGNED
1-1-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | |
| JASON GREIGER, M.D. | | AP 30 CAMERON STREET
SILVER SPRING, MD. | | Removal | |
| 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Jan. 2, 1979 | | George Washington Medical School | | Washington, D.C. | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Capitol Funeral Service Fairfax, Va. | | JAN 5 1979 | | [Signature] | |

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68
35
150
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examination must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director and completely filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filled within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REC. NO. 79-02126 | | | | | | | |
|--|--|----------|--|---|--|--|--|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>Lewis David Ortega</i> | | | | | | | | | | | | ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
<i>Jan 13 1979</i> | | 11:24 PM | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH (MONTH DAY YEAR) | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR | | | | | | | |
| <i>m</i> | | <i>w</i> | | <i>May 5 1956</i> | | <i>22 YRS.</i> | | | | <i>Jan 13 1979</i> | | <i>11:24 PM</i> | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Washington DC</i> | | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery MD.</i> | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Kensington</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>3900 Lawrence Ave</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Food Expert</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>DELICATESSEN</i> | | | | | | | |
| 13a. STATE <i>MD</i> | | | | | | | | | | | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Kensington</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>3900 Lawrence Ave</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>Lewis Ortega</i> | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Lucille Mary Dove</i> | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i> | | | | | | 16b. SOCIAL SECURITY NO.
<i>214 70 1113</i> | | 17. INFORMANT ADDRESS
<i>11801 Rockville Pike
Lewis Ortega Rockville, Md.</i> | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Gunshot Wound of Head</i>
<i>9534</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>None</i> | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
<i>110 PM 1/13/79</i> | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>110 PM 1/13/79</i> | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
<i>Shot Self</i> | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
<i>Home</i> | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
<i>Lawrence Ave, Kensington Mont. Md</i> | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> | | | | | | TITLE (SPECIFY)
<i>Dep</i> | | | | | | DATE SIGNED
<i>Jan 14/1979</i> | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
<i>John S. Rogers, M.D.</i> | | | | | | ADDRESS
<i>1919 Seminary Rd. Silver Spring Maryland</i> | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | | | 23b. DATE
<i>1/16/79</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Parklawn Memorial</i> | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Rockville, Maryland</i> | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME
<i>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</i> | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 18 1979</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Hickey/Kelley</i> | | | | | | | |

5-05150

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-02127 | |
|---|--|--|---|--|--|--|--|---|--|--|--|
| 1- STATE REGISTRAR | | | 1. DECEASED NAME
(TYPE OR PRINT) Jean C. Owens | | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | | 2b. HOUR 28 ⁰⁰ M | |
| 3 SEX FEMALE | | | 4. RACE W. | | 5. DATE OF BIRTH MONTH DAY YEAR 1-11-27 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | | 7b. HOUR 28 ⁰⁰ M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO MD. | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 14528 Bauer Drive | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harley Colberg | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Leroy | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 105-20-7063 | | |
| 17. INFORMANT Paul H. Owens (Same as 13e) | | | 17. ADDRESS | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 9580 Multiple Injuries Severe -
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 130 P.M. 1-22-79 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Slipped in front of farming truck on Beltway | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Beltway 495 | | | 21f. LOCATION South near River Rd. ex. of Bethesda Mont. Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John G. Ball | | | TITLE (SPECIFY) M.D. Deputy | | | MEDICAL EXAMINER | | | DATE SIGNED Jan. 22, 1979 | | |
| EXAMINER'S NAME (TYPE OR PRINT) John G. Ball | | | ADDRESS Old Georgetown Rd., Bethesda, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 1-25-79 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem. | | | 23d. LOCATION CITY OR TOWN Silver Spring COUNTY Md. | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes P.A., Bethesda, Md. | | | 25a. DATE RECEIVED BY REGISTRAR FEB 1 1979 REGISTRAR'S SIGNATURE [Signature] | | | | | | | | |

79-02151

MONTGOMERY CO

SUMMIT HOSPITAL

DECEMBER

1871

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 79-02128 | |
|--|--|---------------------------|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 79-02128 | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
RICHARD WAYNE PAROJINOG | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/> MONTH DAY YEAR
1 8 1979 | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH (MONTH DAY YEAR)
Sept. 20 1956 | | 6. AGE (IN YEARS LAST BIRTHDAY)
22 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR
1 8 19 79 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Van Firm | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2309 Greenery La., Apt. 204 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Simplicio C. Parojinog | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Hale | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
215-72-9785 | | 17. INFORMANT ADDRESS
Mary H. Parojinog (same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wounds of chest</u>
965-
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last.</u>
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
12:45 P.M. MONTH DAY YEAR
1 8 19 79 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
shot by police officers | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
police station | | 21f. LOCATION
Wheaton Glenmont Police Station CITY OR TOWN COUNTY STATE
Montgomery County | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Margareta A. Korell</i> | | | | TITLE (SPECIFY)
M.D. Assistant | | | | MEDICAL EXAMINER
DATE SIGNED 1/8/79 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Margarita A. Korell, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | | 23b. DATE
1-9-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | | | 23d. LOCATION
Alexandria Fairfax Va. COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME
ROBERT A. PUMPHREY | | | | ADDRESS
FUNERAL HOMES P/A MD. | | | | 25a. DATE REC'D. BY REGISTRAR
25b. REGISTRAR'S SIGNATURE | | | |

12-05158

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR Alberta Eloise Payne | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Alberta E. Payne | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Jan 23 1979 | | 2b. HOUR 8:55 P.M. | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR March 17, 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Monte MD. | | | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Legal Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN Wash., DC | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry H. Green | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Flowers | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) no | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) no | | 16b. SOCIAL SECURITY NO. 147 12 8738 | | 17. INFORMANT ADDRESS Michael S. Payne-2211 B Pentland Dr Baltimore, Md, | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema
DUE TO, OR AS A CONSEQUENCE OF (c) Heart Failure
1629
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 49 | | 21f. LOCATION STREET 79 | | CITY OR TOWN | | COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/23 19 79 to 1/24 19 79 , that (I) (we) last saw the deceased alive on 1/23 19 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did (did not) view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE Lewis H. Dennis DEGREE | | | | 22c. DATE SIGNED 1/24/79 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis | |
| 22e. ADDRESS 7600 Carroll Avenue, Takoma Park, Maryland | | | | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/27/79 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN Bladensburg, P.G. Maryland COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME ALEXANDER S. POPE ADDRESS 2617 Pennsylvania Ave., SE D.C. | | | | 25a. DATE REC'D. BY REGISTRAR 1/27/79 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

19-02129

Alberta Elsie Payne

| | | | |
|-------------|-------------------------------|---------------------------------------|--------------|
| Female | Black | March 17, 1903 | 52 |
| New Jersey | United States | xx | |
| Yakima Park | Washington Adventist Hospital | Legal Secretary, U.S. Court | |
| | Wash., D.C. | 1132 14th Street, S.E. | |
| Henry | H. | Green | William |
| no | 197 12 5730 | Michael E. Payne-2011 N. Portland Dr. | Wetmore, Mo. |

1000 Garfield Avenue, Yakima Park, Washington

Marie H. Dennis

1/21/75
St. Lincoln Cemetery
Washburn, S.D. 57150
D.C.
ALANSON & POPE 2017 Pennell Avenue, SE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02130
REG. NO. | |
|--|--|---|--|---|--|---|--|---|----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
HAZEL A PAYNE | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1/22/79 | | | 2b. HOUR
8:45 P. | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH MONTH DAY YEAR
3 34 28 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
WHEATON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
RANDOLPH HILLS N.H. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
BURTON E. RICHARDS | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Helen MURPHY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
577-01-2066D | | 17. INFORMANT ADDRESS
Mrs. Mary P. Windsor (above address) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest
1579
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (c) Fast transition from carcinoma | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15'
24 hrs
2 wks | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Carcinoma of Pancreas | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/15/79 to 1/22/79 , that (I) (we) last saw the deceased alive on 1/22/79 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Robert J. J. J. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
1/23/79 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
1/26/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Brentwood Pr. Geo. Md. | |
| 24. FUNERAL DIRECTOR NAME
Nalley's F.H. Inc. | | | | ADDRESS
Mt. Rainier, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 29 1979 | | 25b. REGISTRAR'S SIGNATURE
Lutney McCready | |

10-05130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02131

REG. NO.

| | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
James | | MIDDLE
Bruce | | LAST
Peer | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 7, 1979 | | | | 2b. HOUR
4:10 | | A
M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
December 30, 1950 | | | | 6. AGE (IN YEARS LAST BIRTHDAY)
28 | | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNOFR 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Clinical Center, NIH, Bethesda | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Timber | | | |
| 13a. STATE
W. Virginia | | 13b. COUNTY
Hampshire | | 13c. CITY OR TOWN
Augusta | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
General Delivery - Route 50 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Virgil Peer, Jr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Carolyn Youngblood | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
233-84-1788 | | 17. INFORMANT
Mrs. Katherine Peer, General Delivery
Augusta, West Virginia 26704 - Route 50 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory failure
1991
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Metastatic Embryonal Cell Carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 18, 1978, to January 7, 1979, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 7, 1979, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Richard Bromer, M.D. | | | | DEGREE
M.D. | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
1-7-79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard Bromer | | | | 22e. ADDRESS
National Institutes of Health
Clinical Center, NIH, Bethesda, MD 20014 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
Jan. 9, 1979 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Fairview | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Gore-Frederick-Virginia | | | |
| 24. FUNERAL DIRECTOR
NAME
W. W. Chambers Co., Silver Spring, Md. | | | | ADDRESS
JAN 11 1979 | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |

79-05131

January 7, 1979

Went

1979

1979

March 17, 1979

Went

1979

T. A. A.

Virginia

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CERTIFICATE OF DEATH

79-02132

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|--|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First Middle Last
Sophia Klein Pfefferle | | | 2a. DATE OF DEATH
1 Month 12 Day 1979 Year | | 2b. HOUR
1:30 P.M. |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
3-7-99 | | 6. AGE (In years last birthday)
79 YRS. | IF UNDER 1 YEAR MONTHS DAYS
- - |
| 7a. BIRTHPLACE (State or foreign country)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH
Rossmoor (Silver Spring) | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Silver Spring Md. Government Printing Office Bookbinding | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Government Printing Office | | 12b. KIND OF BUSINESS OR INDUSTRY
Bookbinding | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN,
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
3314 Chiswick Ct. 62-2F Silver Spring Md. 20906 | |
| 14. FATHER'S NAME First Middle Last
John Joseph Trumbo | 15. MOTHER'S MAIDEN NAME First Middle Last
Anna Katharine Schwint | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | |
| 16b. SOCIAL SECURITY NO.
217-52-5748 | | 17. INFORMANT
Margaret Jarboe 4233 Silver Hill Rd. Suitland Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of Head of the Pancreas</u>
1570 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastases</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 years |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/29/1979, to 1/12/1979, that (I) (we) lost saw the deceased alive on 1/12/1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (and) view the body after death. | | | | | |
| 22b. SIGNATURE
Gustavo S. Belaval MD | | 22c. DATE SIGNED
1/12/79 | 22d. PHYSICIAN'S NAME (Type)
Gustavo S. Belaval | | |
| 22e. ADDRESS
3629 Glen Eagles Dr. S.S. Md. | | 22f. ADDRESS
3629 Glen Eagles Dr. S.S. Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE
1/16/79 | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY | 23d. LOCATION (City or Town)
SUITLAND | (County)
PRI GEO | (State)
MD. |
| 24. FUNERAL DIRECTOR
FRANCIS J. COLLINS | | 25a. REC'D BY REGISTRAR
JAN 16 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | |

10-05135

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02133
REG. NO. | |
|---|--|--|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Richard Brockett Perry | | | | | | 2b. DATE OF DEATH MONTH DAY YEAR
January 10, 1979 | | 2c. HOUR A M
5:10 A M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
January 07, 1936 | | 6. AGE (IN YEARS LAST BIRTHDAY)
43 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Roanoke, Va. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
The Clinical Center, NIH Bethesda Md | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
State Dept. Chief | | 12b. KIND OF BUSINESS OR INDUSTRY
Loan Officer | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Virginia | | | | | | 13b. COUNTY
Fairfax | | 13c. CITY OR TOWN
Falls Church | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
I. Roy Perry | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Evelyn Brockett | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
1958-64 | | 17. INFORMANT ADDRESS
Falls Church, Virginia 20041
Mrs. Hai-yun Perry, 3701 S. George Mason Dr. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral, marked</u>
2387 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myeloproliferative syndrome</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>malignant lymphoma</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week
3 years
1-2 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 09</u> , 19 <u>79</u> , to <u>January 10</u> , 19 <u>79</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>January 10</u> , 19 <u>79</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>A.S. Lichter, M.D.</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/11/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A.S. LICHTER | | | | | | 22e. ADDRESS
of Health, Bethesda, Md. 20014
The Clinical Center, National Institutes | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
burial | | 23b. DATE
1-13-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Evergreen Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Roanoke, Va. | | | |
| 24. FUNERAL DIRECTOR
NAME
Evelyn Wholly FH | | | | | | ADDRESS
Alex Va. | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

BP

70-05133

NAME: Barbara Maria Pfeifer

DATE OF DEATH: January 16, 1979

PLACE OF DEATH: Montgomery County

SEE: #79-04771
February, 1979
Montgomery County

WILLIAMSON

NAME: Joseph Alan Pheasant

DATE OF DEATH: January 24, 1979

PLACE OF DEATH: Montgomery County

SEE: #79-04772
February, 1979
Montgomery County

WINTER 1913

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

DHMH - 16 50M 7/77
(VRA 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02134
REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 1-12-79 | | 545 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| F | | WHITE | | MONTH DAY YEAR
3 31 61 | | 77 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| PA | | USA | | | | MONTGOMERY CO. MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| TAKOMA PARK | | WASHINGTON ADVENTIST HOSPITAL | | FACTORY WORKER | | GARMENT | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| PA | | SOMERSET | | GARRETT | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | BOX 131 | | | |
| ABRAHAM | | SHULTZ | | ALFARETTA | | RUMISER | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| NO | | 170-26-5304 | | DALE PHENICIC | | 3009 ELLICOTT RD
BELTSVILLE MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | 10/15/79 19 79 to 1/12/79 19 79 | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>10/15/79</u> to <u>1/12/79</u> , that (1) (we) lost <u>1/12/79</u> saw the deceased alive on <u>1/12/79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 1/16/79 | | HIGHLAND CEMETERY | | GARRETT SOMERSET CO PA | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| PRICE FUNERAL HOME 325 MAIN ST MEYERSDALE PA | | | | JAN 15 1979 | | [Signature] | |

48150-25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02135
REG. NO. | | | |
|--|--|--|--|--|--|-------------------------------|---|---|--|--|-----------------|-----|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | |
| | | | ELsie C. PHILLIPS | | | | 1-12-79 | | | | 2:45 PM | | |
| 3 SEX | | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Female | | | Caucasian | | Nov 19, 1903 | | 75 | | MONTHS | | DAYS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | MD. | |
| Virginia | | | U.S.A. | | | | Montgomery, | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Rockville | | | Rockville Nursing Home | | | | Homemaker | | | Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | |
| Maryland | | | Montgomery | | Rockville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1210 Broadwood Drive | | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Thomas Elliott | | | | | | Not Available | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | |
| No | | | 577 03 6476 | | | Alton Phillips | | | 5113 Flanders Ave Kensington, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <u>cardio-respiratory failure</u> | | | | | | | | | | 48 hr. | | | |
| 436- DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| (b) <u>cerebral vascular accident</u> | | | | | | | | | | 48 hr. | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) <u>arteriosclerosis</u> | | | | | | | | | | 15 yr. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | STREET | | CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10:45</u> , 19 <u>79</u> , to <u>12 JAN</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12 JAN</u> , 19 <u>79</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | 22c. DATE SIGNED | | | | |
| <u>[Signature]</u> | | | | | | | | | 1/12/79 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | | | |
| JOHN M. KYMAN MD. | | | | | | 7601 MONROE AVE Bethesda, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (CITY OR TOWN COUNTY STATE) | | | | | |
| Burial | | | 1/15/79 | | Parklawn Memorial | | | Rockville, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND | | | | | | JAN 18 1979 | | | <u>[Signature]</u> | | | | |

MEDICAL CERTIFICATION

1102 BP

79-05132

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02136
REG. NO. | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>Mary Edith Phillips</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>1-28-79</i> | | 2b. HOUR
<i>11 A.M.</i> | | | |
| 3. SEX
<i>FEMALE</i> | | 4. RACE
<i>WHITE</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>FEB 3, 1885</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
<i>93 YRS.</i> | | IF UNDER 1 YEAR
IF UNDER 24 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>WASHINGTON, D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>MONTGOMERY MD.</i> | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>TAKOMA PARK</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>WASHINGTON ADVENTIST HOSPITAL</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>HOUSEWIFE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
<i>MARYLAND</i> | | | | 13b. COUNTY
<i>MONTGOMERY</i> | | 13c. CITY OR TOWN
<i>WHEATON</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>2302 GLENMONT CIRCLE</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>STANLEY S. SLACK</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>GERTRUDE BYRD</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>217-46-5154</i> | | 17. INFORMANT ADDRESS
<i>DAUGHTER SILVER SPRING, MD., EDITH E. KEEGIN, 9405 SEMINOLE ST.,</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Stroke (probable)</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>A.S.V.P.</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Intestinal obstruction (resolving)</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19 79</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/13/79</i> to <i>1/28/79</i> , that (I) (we) lost saw the deceased alive on <i>1/27/79</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>H.L. Martner</i> | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>H.L. MARTNER</i> | | | | 22e. ADDRESS
<i>831 University Blvd East S.S. Md.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>BURIAL</i> | | 23b. DATE
<i>a/31/79</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>FT. LINCOLN</i> | | 23d. LOCATION
<i>BRENTWOOD</i> | | CITY GEO | | MD. | |
| 24. FUNERAL DIRECTOR NAME
<i>FRANCIS J. COLLINS</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 29 1979</i> | | | | 25b. REGISTRAR'S SIGNATURE
<i>Henry H. Cuddy</i> | | | |
| 25c. ADDRESS
<i>500 UNIV. BLVD. W. SILVER SPRING, MD. 20901</i> | | | | | | | | | | | |

BP

110111-77

201102.1 230457

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02137

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | MONTH DAY YEAR | |
| Katherine Nichols Pickett | | January 29, 1979 | | 4:50AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| female | white | MONTH DAY YEAR | 83 | IF UNDER 24 HRS | |
| 2a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A. | | Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Olney | Montgomery General Hospital | housewife | home | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | Howard | Clarksville | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 12701 Clarksville Pike | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 17. INFORMANT | | | |
| FIRST MIDDLE LAST | FIRST MIDDLE LAST | 12701 Clarksville Pike | | | |
| Albert L. Nichols | Gertrude K. Cashell | A. Hardy Pickett Clarksville, Maryland 21029 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | | |
| no | 212 36 3689 A | A. Hardy Pickett Clarksville, Maryland 21029 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Severe metabolic (lactic) acidosis</u>
4140
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Mesenteric vascular occlusion (suspected)</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASHD - congestive heart failure</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 hours
12 hours?
2 months |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from <u>Nov 11, 1978</u> to <u>1/29, 1979</u> , that (1) (2) lost saw the deceased alive on <u>1/29, 1979</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death. | | 22b. SIGNATURE
<u>[Signature]</u> MD | | 22c. DATE SIGNED
<u>1/29/79</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| burial | | 1/31/79 | | St. Marks Cem. | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| SLACK Funeral Home, Ellicott City, Maryland 21043 | | FEB 1 1979 | | <u>[Signature]</u> | |

78-05131

SECTION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH-17
(VR A15 ME (5))
15M/7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 79-02138

1- FOR
STATE
REGISTRAR

| | | | | |
|--|----------------------------|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Evelyn Carroll PIGNONE | | 2a. DATE KNOWN OF DEATH
ESTIMATED Jan 5 1979 | | 2b. HOUR
1230 P.M. |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH 3 DAY 30 YEAR 1968 | 6. AGE (IN YEARS)
LAST BIRTHDAY 68 YRS. | 7c. DATE PRONOUNCED DEAD
Jan 5 1979 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
12404 Tampico Way | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE |
| 13a. STATE
MD | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Silver Spring |
| 14. FATHER'S NAME
FIRST FRANCIS MIDDLE S. LAST CARROLL | | 15. MOTHER'S MAIDEN NAME
FIRST SUSZELL MIDDLE ELGIN LAST ELGIN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
578-09-4680 | | 17. INFORMANT
SON ADDRESS ROCKVILLE, MD. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Atherosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) DIS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
None | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE
John S. Rogers | | TITLE (SPECIFY)
Deputy MEDICAL EXAMINER | | DATE SIGNED
Jan 5, 1979 |
| EXAMINER'S NAME
(TYPE OR PRINT) JOHN S. ROGERS | | ADDRESS
1909 SEMINARY ROAD, SILVER SPRING, MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | 23b. DATE
1/8/79 | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
CITY OR TOWN SILVER SPRING COUNTY MONT STATE MD. |
| 24. FUNERAL DIRECTOR
NAME FRANCIS J. COLLINS | | 25a. DATE REC'D. BY REGISTRAR
JAN 8 1979 | | 25b. REGISTRAR'S SIGNATURE
Barbara M. Brady |
| 500 UNIV BLVD., W. SILVER SPRING, MD. 20901 | | | | |

18-05138

17-10-1947

WASHINGTON, D. C. U.S.A.

2710 2nd St. N.E. Wash. D.C.
WASHINGTON, D.C.

| | | | | | | |
|-----|-------------|--------------------|----|---------|-------|------------------|
| NO. | 571-00-4480 | FRANCIS J. COLLINS | 2. | CARROLL | SUSAN | ELLEN |
| | | | | | | ROCKVILLE, MD. |
| | | | | | | 5500 PARKWAY DR. |

1009 SEYMOUR ROAD, SILVER SPRING, MD.

JOHN S. ROBERTS

| | | | | | |
|--|--------------------|--------|---------------|---------------|-----|
| 570 GLEN BLVD., SILVER SPRING, MD. 20901 | FRANCIS J. COLLINS | 1/2/79 | DATE OF BIRTH | SILVER SPRING | MD. |
|--|--------------------|--------|---------------|---------------|-----|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02139
REG. NO. | |
|---|--|---|--|--|--|--|--|---|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) PHILIP BURNET PITTLE | | | | | | 2a. DATE OF DEATH
MONTH 1 DAY 30 YEAR 79 | | | 2b. HOUR
9:03 AM | | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH
MONTH APRIL DAY 15 YEAR 1899 | | 6 AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
POLAND | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BAKER | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
MARYLAND | | 13b COUNTY
MONTGOMERY | | 13c CITY OR TOWN
SILVER SPRING | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
7913 TAKOMA AVENUE | | | |
| 14 FATHER'S NAME
FIRST ABRAHAM MIDDLE LAST PITTLE | | | | 15. MOTHER'S MAIDEN NAME
FIRST BELLA MIDDLE LAST TRAVA | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b SOCIAL SECURITY NO.
218-34-5659 | | 17. INFORMANT
ADDRESS 7913 TAKOMA AVENUE
FRANCES PITTLE, WIFE SILVER SPRING, MD. | | | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac Arrest
481-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Acute MF
DUE TO, OR AS A CONSEQUENCE OF
(c) Lobar Pneumonia, hypoxia, septicemia
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a I certify that (1) (this hospital) attended the deceased from 1/30 , 19 79 , to 1/30 , 19 79 , that (1) (we) last saw the deceased alive on 1/30 , 19 79 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE
DR. ROBERT HALLOWITZ, MD. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c DATE SIGNED | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
DR. ROBERT HALLOWITZ, MD | | | | 22e ADDRESS
11119 ROCKVILLE PIKE, SUITE 502
ROCKVILLE, MARYLAND | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b DATE
FEB. 2, 1979 | | 23c NAME OF CEMETERY OR CREMATORY
KING DAVID MEM. GARDEN | | 23d LOCATION
CITY OR TOWN COUNTY STATE
FALLS CHURCH VIRGINIA | | | | | |
| 24. FUNERAL DIRECTOR'S NAME
DR. M. STEIN HEB. MEM. FUNERAL HOME
232 CARROLL ST., N.W., WASH. D.C 20012 | | | | | | 25a DATE REC'D. BY REGISTRAR
FEB 5 1979 | | 25b REGISTRAR'S SIGNATURE
Anthony McCready | | | |

MEDICAL CERTIFICATION

BP

28-05132





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 79-02140 | |
|--|--|--|---|---|---|
| 1. FOR STATE REGISTRAR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Margaret Agnes Ponton | | | 2a. DATE OF DEATH MONTH DAY YEAR
01 07 79 | | 2b. HOUR
11:55 P.M. |
| 3 SEX
FEMALE | 4 RACE
WHITE | 5. DATE OF BIRTH MONTH DAY YEAR
NOV 3, 1922 | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
56 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10 CITY OR TOWN OF DEATH
olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Montgomery Gen. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
MARYLAND | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
SILVER SPRING | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
15301 WALLBROOK COURT, | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
WALTER T. WILKINSON | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
AGNES C. FOX | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
577-24-4664 | 17. INFORMANT SISTER ADDRESS
BALTIMORE, MD. ANNA MARIE DUNMIRE, 1717 NORTHBOURNE ROAD | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEPATORENAL SYNDROME
577/5 DUE TO, OR AS A CONSEQUENCE OF (b) CIRRHOSIS OF THE LIVER
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 WEEKS
YEARS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
GASTROINTESTINAL BLEEDING | | | | | |
| 19a. DATE OF OPERATION
NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 18 , 19 78 , to JANUARY 7 , 19 79 , that (I) (we) lost saw the deceased alive on JANUARY 7 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Barry Hecht | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/8/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARRY HECHT | | 22e. ADDRESS
10620 GEORGIA AVENUE SILVER SPRING | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | 23b. DATE
1/10/79 | 23c. NAME OF CEMETERY OR CREMATORY
ROCK CREEK CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
WASHINGTON, D.C. | |
| 24. FUNERAL DIRECTOR NAME
FRANCIS J. COLLINS | | 25a. DATE REC'D. BY REGISTRAR
JAN 10 1979 | | 25b. REGISTRAR'S SIGNATURE
Barry Hecht | |
| 500 UNIVERSITY BOULEVARD WEST, SILVER SPRING, MD. | | | | | |

79-02140

| | | | |
|-------------------------|-------------|-------|--------|
| 79-02140 | NOV 2, 1961 | WHITE | FEMALE |
| WASHINGTON, D.C. U.S.A. | | | |
| 15801 MILLBROOK COURT | | | |
| WALTER T. WILKINSON | | | |
| 79-24-1881 | | | |

WALTER T. WILKINSON
79-24-1881

WASHINGTON, D.C. U.S.A.
15801 MILLBROOK COURT
WALTER T. WILKINSON
79-24-1881

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-02141

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Clarence Russell Pope | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 27, 1979 | | | 2b. HOUR
1:55a
M | | | |
| 3 SEX
Female | | 4 RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 20 1899 | | 6 AGE (IN YEARS LAST BIRTHDAY)
79
YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery
MD. | | | |
| 10 CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Supt. of Mail | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Post off. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Derwood | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7500 Miller Fall Rd. | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Charles Edward Pope | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Daisy Edmondson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- | | 17 INFORMANT
Elizabeth Pope | | ADDRESS
7500 Miller Fall Road,
Derwood, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial infarction
410 - DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic Coronary Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Coronary Heart Disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 11/27 , 19 79 , to 1/27 , 19 79 , that (1) <input checked="" type="checkbox"/> last saw the deceased alive on 1/27 , 19 79 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (1) <input type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
John G. Lodmell M.D. | | | | | | DEGREE
M.D. | | 22c. DATE SIGNED
1/27/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John G. Lodmell, M.D. | | | | | | 22e. ADDRESS
18111 Prince Phillip Drive, Olney, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Jan. 29, '79 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Stephen's City Fred. Va. | | | |
| 24. FUNERAL DIRECTOR
Gartner-Sandison 316 E. Diamond Ave.
Gartner-Sandison F.H. Gaithersburg, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 31 1979 | | 25b. REGISTRAR'S SIGNATURE
Henry McCurdy | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

14150-07

January 27, 1972

Charles Russell

Location

Montgomery General Hospital

Olney

unsub

1-1-72



14150

14150-07

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR | | REG. NO. 79-02142 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
William J. Porter | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
Jan 11 1979 | | | 2b. HOUR
2 P M | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
MARCH 27, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Carriage Hill Bethesda Cedar La | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY
CHRYSLER CORP. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2725 29TH ST. N.W. | | |
| 13a. STATE
— | | 13b. COUNTY
— | | 13c. CITY OR TOWN
WASH. DC | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William B. Porter | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
CATHERINE A. GORMAN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
WWI | | 17. INFORMANT ADDRESS
137-09-9385 FRANCIS J. ORTMAN 7101 WISC. AVE WASH. DC | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiorespiratory Collapse
4151 } DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Embolism acute
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Advanced age, inactivity
DUE TO, OR AS A CONSEQUENCE OF (c) many yrs. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
sudden |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.
Cerebral arteriosclerosis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
11125 Rockville Pike #103, Rockville, Md. | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 20, 1978 to Jan 11, 1979 , that (I) (we) last saw the deceased alive on 12/19 19 78 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
George H. Mitchell MD | | | | DEGREE | | 22c. DATE SIGNED
1/11/79 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
George H. Mitchell | | | | 22e. ADDRESS
11125 Rockville Pike #103, Rockville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1-15-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Sepulchre Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
NORTH ANDOVER 20852 MASS | | | |
| 24. FUNERAL DIRECTOR NAME
John E. Deibel | | | | ADDRESS
DEVEL FUNERAL HOME WASH DC | | 25a. DATE REC'D. BY REGISTRAR
JAN 17 1979 | | 25b. REGISTRAR'S SIGNATURE
Henry McCreedy | |

10-05145

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02143 | | |
|---|--|---|--|---|--|---|--|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | | | | | | | | | REG. NO. | | |
| 1. DECEASED NAME
(TYPE OR PRINT) DAISEY POWELL | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 1 1 / 1 79 | | | | 2b. HOUR 12:05 AM | | |
| 3. SEX
F | | 4. RACE
N | | 5. DATE OF BIRTH
MONTH DAY YEAR
10- 20-1896 | | 6. AGE (IN YEARS, LAST BIRTHDAY)
82 yrs. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
School Principal | | | 12b. KIND OF BUSINESS OR INDUSTRY
Education | | | |
| 13a. STATE
D. C. | | | | 13b. COUNTY
none | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1112 Park Road, N. W. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
unavailable | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
unavailable | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO.
578-62-2198T | | 17. INFORMANT
Washington, D. C. | | 17. ADDRESS
2466 Ontario Road, N. W. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Confluent, bilateral bronchopneumonia.
436-
DUE TO, OR AS A CONSEQUENCE OF
(b) Paralysis - parietal of resp. musculature
DUE TO, OR AS A CONSEQUENCE OF
(c) ECVA 2° to Hypertensive, arteriosclerotic cerebrovasc. dis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/26 , 19 78 , to 1/1 , 19 79 , that (I) (we) last saw the deceased alive on 12/31/78 , 19 78 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Thomas R. Garvey III, M.D. | | | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/1/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THOMAS R. GARVEY III, M.D. | | | | | | 22e. ADDRESS
50 W. Edwards Dr. Rockville, Md. 20852 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
1-05-'79 | | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Prince Georges' County, Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Latney's Funeral Home | | | | | | ADDRESS
3831 Georgia Avenue, N. W. | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1979 | | 25b. REGISTRAR'S SIGNATURE
Joseph McCreedy | | |

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02144
REG. NO.1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Kathryn V. Power | | | 2a. DATE OF DEATH MONTH DAY YEAR
January 29, 1979 | | 2b. HOUR
9:59AM | | | | |
| 3 SEX
F | | 4. RACE
CAU. | | 5. DATE OF BIRTH MONTH DAY YEAR
2 5 26 | | 6. AGE (IN YEARS LAST BIRTHDAY)
52 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MASSACHUSETTS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
14313 BLACKMON Dr. | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
THOMAS H. DEMPSEY, SR. | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
KATHRYN MOORE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
031-12-0151 | | 17 INFORMANT ADDRESS
JEROME F. POWER SAME AS 13 HUSBAND | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Leukemia, Acute myelocytic</u>
2050 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>GRAM NEGATIVE SEPSIS</u>
(c) <u>SHOCK LUNG</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
John R. Minarcik | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
1/29/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John R. Minarcik | | | | 22e. ADDRESS
18101 Prince Philip Dr. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
2/1/79 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | | |
| 24 FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1979 | | 25b. REGISTRAR'S SIGNATURE
Ruthy McCreedy | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-02145 | |
|--|--|------------------|--|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Michael Anthony Pullen | | | | | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR
1 26 19 79 | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
Sept. 16, 1961 | | 6. AGE (IN YEARS) (EAST BIRTHDAY) MONTHS DAYS HOURS MIN
17 YRS. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR
1 26 19 79 | | 2b. HOUR
7:35 P. M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
APC Mech. | | 12b. KIND OF BUSINESS OR INDUSTRY
Auto | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1602 Marshall Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Bunny Pullen | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Nancy Hinkle | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
-- | | 17. INFORMANT ADDRESS
Bunny Pullen same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stabwound of chest
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
6:55 P.M. 1/26 19 79 | | | | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR
stabbed | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
street | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
2001 McAlliff Dr. Rockville, Montgomery MD | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan M.D. | | | | | | TITLE (SPECIFY)
Assistant | | MEDICAL EXAMINER | | DATE SIGNED 1/27/79 | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | | | | ADDRESS 111 Penn St. Balto, MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
1/30/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Silver Spring, Md. | |
| 24. FUNERAL DIRECTOR NAME
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Md. 20852 | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 1 1979 | | | | | |

24150-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) **John E. Randels**

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02146
REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) John E. Randels | | | 2a. DATE OF DEATH MONTH DAY YEAR 01-03-79 | | | 2b. HOUR 6:15 PM | | | |
| 3. SEX M | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10-29-05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.J. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHARMACIST | | 12b. KIND OF BUSINESS OR INDUSTRY DRUG STORES | |
| 13a. STATE MD | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 8404 Tahona Dr - 20903 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Not Known | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Known | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 577-09-5325 | | 17. INFORMANT ADDRESS JOHN E. RANDELS - COLLEGE PARK - MD. | | | | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-pulmonary failure
1570
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinomatosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) Carcinoma of Head of Pancreas | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hrs.
4-6 mos
4-6 mos | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION 12/18/78 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Head of Pancreas | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/15/78 to 1/3/79 , that (I) (we) lost saw the deceased alive on 4/3/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Steven Christian MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/3/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven Christian | | 22e. ADDRESS 344 University Blvd W. Silver Spring MD | | | | | |

| | | | | | | | |
|---|--|-------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 1/5/79 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREM | | 23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND - PG-MD | |
| 24. FUNERAL DIRECTOR NAME W.W. CHAMBERS CO. MARYLAND | | | | 25a. DATE REC'D. BY REGISTRAR JAN 11 1979 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

78-05148

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02147
REG. NO. | |
|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | 1 DECEASED NAME
(TYPE OR PRINT) NINA COLE RAY | | | | 2a. DATE OF DEATH
MONTH 1 DAY 3 YEAR 79 | | 2b. HOUR
1:15 A | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 7 DAY 1 YEAR 87 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS
HOURS 0 MIN 0 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) OHIO | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD | | | | | |
| 10. CITY OR TOWN OF DEATH
CHEVY CHASE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET)
3904 Blackthorn St. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a. STATE
MD | | | 13b. COUNTY
MONTGOMERY | | | 13c. CITY OR TOWN
CHEVY CHASE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3904 BLACKTHORN ST. | |
| 14. FATHER'S NAME
FIRST ELMER MIDDLE ELLSWORTH LAST COLE | | | 15. MOTHER'S MAIDEN NAME
FIRST MARY MIDDLE NAOMI LAST SINCLAIR | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-46-8353 | | | 17. INFORMANT
Son | | | ADDRESS
CHEVY CHASE 3904 BLACKTHORN ST | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) congestive heart failure
4149
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) arteriosclerotic coronary artery disease
(c) generalized arteriosclerosis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 yrs.
3 yrs.
5 yrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 3 , 19 79 , to Jan. 3 , 19 79 , that (I) (we) last saw the deceased alive on Jan. 3 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Thomas L. Hartman M.D. | | | | | | DEGREE
M.D. | | | 22c. DATE SIGNED
1/3/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THOMAS L. HARTMAN | | | | | | 22e. ADDRESS
3301 NEW MEXICO N.W. WASHINGTON, D.C. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
1/7/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Windy Cove Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Millboro Springs, Virginia | | | |
| 24. FUNERAL DIRECTOR
NAME
JOSEPH CAWLER'S SONS INC.
ADDRESS
6130 WISC. AVE., N. W. WASH., D. C. 20016 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 8 1979 | | 25b. REGISTRAR'S SIGNATURE
Anthony M. Brady | | | |

79-02147

WILLIAM C. RAY

21

WILLIAM C. RAY

21

(11)

MONROE COUNTY

CHIEF CLERK

MISSISSIPPI

MISSISSIPPI

21

MISSISSIPPI

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MISSISSIPPI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02148
REG. NO. | | |
|---|--|---|--|---|--|--|--|---|--------|--|-------|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Henry | MIDDLE
B. | LAST
Reed | 2a. DATE OF DEATH
MONTH DAY YEAR
January 21, 1979 | | | 2b. HOUR
11:26a | | |
| 3. SEX
Male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 7 93 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 | | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY
Railroad | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. COUNTY
Maryland | | 13b. CITY OR TOWN
Montgomery | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
15317 Basswood Court | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nona UNKNOWN | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
716 05 5857 | | 17. INFORMANT
ADDRESS
Doris Daniels same as 13e | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest
2114
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: }
DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Failure
DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Embolism
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Resection of Recto Sigmoid Colon | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19a. DATE OF OPERATION
1/15/79 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Vitro Placenta Rupt-Spont | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET
3906 Bel Pre Rd | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Robert A. Barnett M.D. | | | | | | | | | | 22c. DATE SIGNED
1/20/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT A. BARNETT, M.D. | | | | | | | | | | 22e. ADDRESS
3906 Bel Pre Rd | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/24/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Altoreste Cemetery | | | 23d. LOCATION
CITY OR TOWN
Blair County Altoona, Pa. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Tyson Wheeler Funeral Home, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 24 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | |
| 1331 Rockville Pike Rockville, Maryland | | | | | | | | | | | | |

84150-01

11:54

STOL, IS YOUNG?

Dear

From

1/11

STOL, IS YOUNG?

STOL, IS YOUNG?

STOL, IS YOUNG?

STOL, IS YOUNG?

STOL, IS YOUNG?

STOL, IS YOUNG?

STOL, IS YOUNG?

STOL, IS YOUNG?

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---------|--|---|---|-------------------|--|--|--|---|--|--------------------------------------|--|-----------|----------------------------|--|--|--|--|
| 1- REGISTRAR | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | FIRST MIDDLE LAST | | | | | 2a. DATE KNOWN OF DEATH | | | | | 2b. HOUR | | | | |
| Ralph Odell Reid | | | | | | | | | | 1/12 19 79 | | | | | 7:22 A.M. | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR | | | | | |
| Male | | White | | Jan. 26, 1921 | | 57 YRS. | | | | | | 1/12 19 79 | | 7:22 A.M. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| MARYLAND | | | | U.S.A. | | | | | | | | Montgomery County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Silver Spring | | | | 11703 Highview Avenue | | | | FIREFIGHTER | | | | NAVY DEPT. | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | | | Montgomery | | Silver Spring | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 11703 Highview Avenue | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | | | | | | | | | | | |
| RALPH R. REID | | | | | GENEVIEVE THOMPSON | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ADDRESS | | | | | | | | | |
| YES | | | | | WW II | | | | | 578-05-4254 ROSEMARY D. REID SAME AS 13 WIFE | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | |
| (b) <u>arteriosclerotic cardiovascular disease.</u> | | | | | | | | | | Years | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? | | | | | | | | | |
| None | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| | | | | | P.M. 19 | | | | | None | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | TITLE (SPECIFY) | | | | | DATE SIGNED | | | | | | | | | |
| <i>John S. Rogers</i> | | | | | M.D. Deputy | | | | | 1/12/79 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | ADDRESS | | | | | | | | | | | | | | |
| John S. Rogers, M.D. | | | | | 1919 Seminary Road Silver Spring, Montgomery, Md. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | |
| BURIAL | | | | | 1/15/79 | | | | | GATE OF HEAVEN | | | | | | | | | |
| 23d. LOCATION CITY OR TOWN | | | | | 23e. COUNTY | | | | | 23f. STATE | | | | | | | | | |
| SILVER SPRING | | | | | MONT | | | | | MD. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| FRANCIS J. COLLINS | | | | | | | | | | JAN 16 1979 | | | | | <i>Patricia McBrady</i> | | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD, 20901 | | | | | | | | | | | | | | | | | | | |

NAME: Joseph Garrett Reilly

DATE OF DEATH: January 15, 1979

PLACE OF DEATH: Montgomery County

SEE: 79-04787
February, 1979
Montgomery County

WINTER 1915

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02150
REG. NO.

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Richard S. Reinke</i> | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>1-18-79</i> | | 2b. HOUR
<i>12:30 PM</i> | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>DEC 12, 1927</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>51</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring, Md.</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Holy Cross</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RESEARCH ANALYST | | 12b. KIND OF BUSINESS OR INDUSTRY
CIVIL DEFENSE |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
ROCKVILLE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DORIS GORNY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
190-20-2891 | | 17. INFORMANT
ADDRESS
MARY ANN REINKE SAME AS 13 WIFE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coma</i>
1629
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiac injury</i>
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>4 1/2 hrs.</i>
<i>6 mo</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/18</i> 19 <i>79</i> to <i>1/18</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>11/18</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Hubert J. Apert, MD</i> | | DEGREE
MD | | 22c. DATE SIGNED
<i>1/18/79</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Hubert J. APERT | | 22e. ADDRESS
8C 30 FENIX ST. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
<i>1/22/79</i> | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | 25a. DATE REC'D. BY REGISTRAR
JAN 19 1979 | |
| 25b. REGISTRAR'S SIGNATURE
<i>Dorothy McCready</i> | | 25c. ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | |

19-05120

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-02151

| | | | | | | | | | | | | | | | |
|---|---------|---|--|---|--|--|--|---|--|--------------------------------------|--|--|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | |
| ALFRED | | JOHN | | RINE | | 17 19 79 | | | | 4A | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR | |
| M | Cauc | 1 21 29 | | 49 YRS. | | | | | | 1 17 19 79 | | | | 510 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| DC. | | USA | | | | | | | | MONTGOMERY | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| CHEVY CHASE | | 8800 ALTIMONT LANE | | | | | | TEACHER | | | | MUSIC | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | |
| MD | | MONT | | CHEVY CHASE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 8800 ALTIMONT LANE | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| LOUIS | | | | RINE | | | | MARY | | | | GERACI | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | |
| YES | | | | 579-34-4765 | | | | JULIA RINE | | | | SISTER SAME | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) <u>CORONARY ARTERIOSCLEROSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>ACUTE</u>
<u>INDEF</u> | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | 1 17 19 79 | | | | FOUND ON FLOOR | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | |
| | | | | HOME | | | | AS ABOVE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | |
| FRANCIS C MAYHE JR | | | | 8200 Wisconsin Ave | | | | BETHESDA | | | | MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | |
| Burial | | Jan. 20, 1979 | | Ft. Lincoln Cem. | | | | Bladensburg, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| NAME | | | | ADDRESS | | | | | | | | | | | |
| Robert A. Pumphrey Funeral Homes, P.A. | | | | Bethesda, Maryland | | | | JAN 23 1979 | | | | [Signature] | | | |

73-05121

2071 - 12 - 72

Ringens: 10

Robert A. Munnich, Jr.

• • • • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02152

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 1-28-79 | | 8 p.m. | |
| 3 SEX | | RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | White | | MONTH DAY YEAR | | 80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 75 Pennsylvania | | USA | | Montgomery | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 71 Takoma Park | | Washington Adventist Hospital | | Retired | | Civil Eng. | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| 35 Maryland | | Montgomery | | Rockville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | | |
| 451 Jonah | | Roberts | | Jennie | | Parrish | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 1 yes | | WW I | | 397-20-1912 | | Beulah I. Roberts-wife-(same as 13e) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 410- | | DUE TO, OR AS A CONSEQUENCE OF | | Cardiogenic Shock | | 72 hour | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last | | (b) | | Anterior Myocardial Infarction | | 10 1/2 days | |
| (c) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | Hypertension, anemia, Rapidly Progressive Renal Failure | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN COUNTY STATE | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | Dec 9 19 54 | | to 28 Jan 19 79 | | that (I) (we) last saw the deceased alive on 28 Jan 19 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| Russell B. Arnold M.D. | | M.D. | | 1/28/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 106 Spring Street | | Silver Spring, Md 20910 | |
| Russell B. Arnold M.D. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | Jan. 31-79 | | Parklawn Cemetery | | Rockville Montgomery Md. | |
| 24. FUNERAL DIRECTOR'S NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Wagner E. Pumphrey, Inc. | | 8434 Ga. Ave., S.S. Md. | | FEB 1 1979 | | Anthony McCready | |

19-05125

Male
1-1-58
1-1-58

James Earl Ray
1-1-58

Raymond J. Franklin Drive

James Earl Ray

James Earl Ray

James Earl Ray

James Earl Ray

James Earl Ray

James Earl Ray

James Earl Ray

James Earl Ray

James Earl Ray

James Earl Ray

James Earl Ray

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the records after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-02153

| | | | | | |
|--|---|---|---|---|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | MONTH DAY YEAR | | 12 11 AM | |
| FIRST MIDDLE LAST
Miriam M. Roberts | | JANUARY 23, 1979 | | 11 AM | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Female | White | MONTH DAY YEAR
3 03 1912 | 66 YRS. | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Wash., D.C. | USA | | Montgomery Co. MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Rockville | Collingswood Nursing Center | | Art Teacher | Self emp. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Md. | Montg. | Bethesda | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 4604 Windsor Lane | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
| FIRST MIDDLE LAST
Samuel K. Miller | | | FIRST MIDDLE LAST
Nancy Belle Proffitt | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | |
| No | | 122-01-26234 | P.O. Box 277
John L. Roberts Middletown, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CARCINOMA COLON</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year
1 year | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| 12/77 | | Colon Ca | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. certify that (I) (this hospital) attended the deceased from 1/11/79, to 1/23/79, that (I) (we) last saw the deceased alive on 1/23/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | 22b. SIGNATURE
DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> | |
| Thos G. WARD | | 6116 Robinwood Bethesda Md | | 1/23/79 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | Jan. 26, 1979 | | Parklawn Cem. | |
| 23d. LOCATION
CITY OR TOWN | | 23e. COUNTY | | 23f. STATE | |
| Rockville, Md. | | Montg. | | MD | |
| 24. FUNERAL DIRECTOR
NAME | | 24b. ADDRESS | | 25a. DATE RECEIVED BY REGISTRAR | |
| Robert A. Pumphrey Funeral Homes, P.A. | | Bethesda, Md. | | FEB 14 1979 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |
| R. A. Pumphrey | | | | | |

79-05123

PROFIT

Wells

Wells

Wells

Wells

123-01-30534 John E. Roberts

123-01-30534 John E. Roberts

123-01-30534 John E. Roberts

123-01-30534 John E. Roberts

123-01-30534 John E. Roberts

123-01-30534 John E. Roberts

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123-01-30534 John E. Roberts

123-01-30534 John E. Roberts

123-01-30534 John E. Roberts

123-01-30534 John E. Roberts

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02154 | |
|---|--|---|--|---|--|---|--|--|---|--|--|
| FOR
1- STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) Jeannette V. Rogers | | | | | | 2a. DATE OF DEATH
MONTH 1 DAY 21 YEAR 79 | | | 2b. HOUR
12²⁷ P.M. | | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH
MONTH 9 DAY 3 YEAR 11 | | 6 AGE (IN YEARS LAST BIRTHDAY)
67 YRS | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) PA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE OF OTHER PERSON)
13a. STATE md. 13b. COUNTY Montg. 13c. CITY OR TOWN SILVER SPRING | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1220 BLAIR MILL ROAD
XZXZXZXZXZXZXZXZXZXZXZXZXZXZXZXZX | | | |
| 14. FATHER'S NAME
FIRST CURTIS MIDDLE WEIGAND LAST WEIGAND | | | | 15. MOTHER'S MAIDEN NAME
FIRST HALLIE MIDDLE HALLIE LAST HALLIE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
198-12-9355 | | 17 INFORMANT Thomas Rogers (Son) ADDRESS 10028 WEATHERWOOD COURT, POTOMAC, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
436-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Central Vascular Accidents
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 week | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 10 19 78 to Jan 21 19 79 , that (I) (we) lost
saw the deceased alive on Jan 21 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22a. SIGNATURE
Howard S. Goldstein | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Jan 21, 79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HOWARD S. Goldstein | | | | 22e. ADDRESS
4701 Randolph Rd, Rockville | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | | | 23b. DATE
1/25/79 | | 23c. NAME OF CEMETERY OR CREMATORY
STS. PETER AND PAUL | | 23d. LOCATION
MARPLE TOWNSHIP DEL PA. | | | |
| 24. FUNERAL DIRECTOR
NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 22 1979 | | 25b. REGISTRAR'S SIGNATURE
Henry McCurdy | | | |

10-05124

10

DATE: JAN 1961

RE: [illegible]

ON: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02155 | | | |
|--|--|---|---|---|------------------------------------|---|---|
| 1. FOR
STATE
REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | |
| LOUIS ANTHONY ROMANO | | | | | | Jan 2 nd , 79 | |
| 3. SEX | | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR |
| Male | | WHITE | 11-17-26 | | 52 YRS. | | 3:10 P.M. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MARYLAND | | U.S.A. | | | | MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| TAKOMA PARK | | WASHINGTON ADVENTIST HOSPITAL | | PLUMBER | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS | |
| 13a. STATE 13b. COUNTY
MARYLAND PRI GEORGES BELTSVILLE | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4502 YATES ROAD | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | |
| PASQUAL ROMANO | | | SANTA | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| YES | | | KOREA 213-20-6245 | | NANCY GARON ROMANO SAME AS 13 WIFE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Severe Congestive Cardiomyopathy</u>
<u>4254</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>with Congestive Heart Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Severe Emphysema</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | |
| - | | - | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 29</u> , 19 <u>78</u> , to <u>1-2</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12-28</u> , 19 <u>78</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED | |
| <u>Suresh C. Gupta</u> | | | | | | 1-3-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | |
| SURESH C. GUPTA | | | 3503 PERRY ST., MT. RAINIER, MARYLAND | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| BURIAL | | 1/5/79 | | GATE OF HEAVEN | | SILVER SPRING MONT MD. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| FRANCIS J. COLLINS
500 UNIV. BLV D., W., SILVER SPRING, MD. 20901 | | | | JAN 8 1979 | | <u>Henry McCreedy</u> | |

10-05122

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02156
REG. NO.1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|--|---|---|--|--|---|------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Jesse L. Rutledge | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 27, 1979 | | | 2b. HOUR
2:25 a | | | | |
| 3. SEX
Male | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 26 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Self employed Home Repair | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET ADDRESS
9704 Digging Road | | | 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWI | | 17. INFORMANT
ADDRESS
Anne R. Warner (Same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>
4149
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>Chronic Coronary Artery Disease</u>
6 yrs
DUE TO, OR AS A CONSEQUENCE OF:
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>Ventricular Arrhythmia.</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>30 hrs</u> | | |
| 19a. DATE OF OPERATION
- | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>1/16/79</u> , 19____, to <u>1/27/79</u> , 19____, that (I) (we) last
saw the deceased alive on <u>1/26/79</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Robert A. Pumphrey</u> | | | DEGREE
<u>MD</u> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>1/27/79</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>R. A. PUMPHREY</u> | | | 22e. ADDRESS
<u>10620 Ga. Av. SS R 1</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
1-30-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Va. | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Md. | | | 25a. DATE RECEIVED BY REGISTRAR
FEB 5 1979 | | | 25b. REGISTRAR'S SIGNATURE
<u>Robert A. Pumphrey</u> | | | | |

10-05120

January 27, 1978

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02157
REG. NO. | |
|---|--|--|--|---|--|--|--|---|--|----------------------|--|
| 1. FOR STATE REGISTRAR | | 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>TERESA ANN CHAMBERS SALATTO</i>
<i>Teresa Ann Salatto</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>1 - 31 - 79</i> | | 2b. HOUR
<i>11:37 AM</i> | | | |
| 3 SEX
<i>Female</i> | | 4 RACE
<i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>2 10 35</i> | | 6 AGE (IN YEARS LAST BIRTHDAY)
<i>43</i> YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Holy Cross Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Home Maker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Home</i> | | | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Wheaton</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>12603 Farnell Dr.</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>David Chambers</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Teresa Neuland</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>579-46-2069</i> | | 17. INFORMANT <i>Husband</i> ADDRESS
<i>Frank J. Salatto, Same as item 13.</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i>
<i>4151</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>1/30/79</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>1</i> | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
<i>1</i> | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
<i>1</i> | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>19 75</i> to <i>31 Jan 19 79</i> , that (I) (we) last saw the deceased alive on <i>30 Jan 19 79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Merton L. White M.D.</i> | | | | 22c. DEGREE
<i>M.D.</i> | | | | 22d. DATE SIGNED
<i>31 Jan 79</i> | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Merton L. WHITE, M.D.</i> | | | | 22f. ADDRESS
<i>9911 Georgia Ave Silver Spring, Md 20902</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>2/3/1979</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>St. John's Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Silver Spring, Maryland</i> | | | | | |
| 24. FUNERAL DIRECTOR NAME
<i>JOSEPH & CAWLER'S SONS INC.</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>FEB 5 1979</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Anthony J. ...</i> | | | | | |

25-05121

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TO HOSPITALS: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02158
REG. NO. | |
|--|--|---|---|--|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Betty E Salins | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1 15 79 | | | 2b. HOUR
2:15 P.M. | |
| 3 SEX
Female | | 4 RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
11 16 24 | | 6 AGE (IN YEARS LAST BIRTHDAY)
54 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Massachusetts | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a. STATE
Md | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Wheaton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10 Beechvue Ct | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Julius Robinson | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Sadie Wolfe | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
579-20-5781 | | 17 INFORMANT
Sidney Salins, 10 Beechvue Ct., | | | ADDRESS
Maryland Silver Spring | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Shock
1749
DUE TO, OR AS A CONSEQUENCE OF
(b) Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(c) Carcinoma Breast | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 hr
1 hr
4 hr | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 12, 1929, to 1115, 1979, that (I) (we) lost saw the deceased alive on 1115, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
C. Sedra | | | | | | DEGREE
M.D. | | | 22c. DATE SIGNED
11151979 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDGAR H. LEVIN | | | | | | 22e. ADDRESS
8630 FEATHERS + | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
1-17-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Judean Mem. Garden | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Olney Montg. Maryland | | | |
| 24. FUNERAL DIRECTOR NAME
Danzansky-Goldberg Mem. Chap. | | | | | | ADDRESS
Rockville, Md. 1170 Rockville Pk | | | 25a. DATE REC'D. BY REGISTRAR
JAN 22 1979 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Phyllis McCreedy | | | | | |

18-05128

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02159
REG. NO. | | | |
|---|--|---|--|---|--|---|--|--|-----------------------------------|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) SAMAN M SAMAN | | | | | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-10-79 | | 2b. HOUR
6:30 A.M. | |
| 3. SEX
M | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
8-2-22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PALESTINE | | 7b. CITIZEN OF WHAT COUNTRY?
PALESTINE | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TAILOR | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN TAKOMA PARK | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
8602 GREENWOOD AVENUE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MOUSAS SAMAN | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
HANNAH SHAIB | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
216-64-4158 | | 17. INFORMANT
ADDRESS
JOHN SAMAN SAME AS 13 SON | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory arrest
0382
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumococcal meningitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) Pneumococcal sepsis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
hrs
1-2 days | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Alcoholism Liver failure | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1-9 19 79 , to 1-10 19 79 , that (1) (we) lost saw the deceased alive on 1-9 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
John Ford MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/10/79 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN L FORD | | | | 22e. ADDRESS
344 University Blvd W Silver Spring Md, 20901 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
1/13/79 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1979 | | | | 25b. REGISTRAR'S SIGNATURE
Jeffrey Kennedy | | | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | | | | | |

79-05129

WINTER

SHAW



MONTGOMERY

BALESTINE

BALESTINE

TAYLOR

WASHINGTON ADVENTIST HOSPITAL

TAKOMA PARK

8000 GREENWOOD AVENUE

X

MONTGOMERY TAKOMA PARK

MARYLAND

SHAW

HANNAH

SHAW

SHAW

SON

SON AS IS

JOHN SHAW

212-64-4152

NO



500 UNIT, BLVD. W. ST. LOUIS, MO. 63101
FRANCIS J. COLLIS
DATE 11/12/79
ST. LOUIS, MO. 63101
JAN 12 1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02160
REG. NO.

| | | | | | |
|--|---|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | MONTH DAY YEAR | | HOURS MIN | |
| JEAN V. SAPIR | | 1 24 79 | | 5 05 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| FEMALE | CAUCASIAN | MONTH DAY YEAR | 79 | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| CANADA | U.S.A. | | MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| OLNEY | BROOKE GROVE NURSING HOME | | SOCIAL WKR. | | STATE OF CONN. |
| 13a. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. INSIDE CITY LIMITS? | 13c. STREET ADDRESS | | |
| N.H. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | UNKNOWN | | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST | FIRST MIDDLE LAST | | | | |
| JAMES E. MCLEENAGHAN | JULIA CASS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | | |
| NO | 002-32-2422 | HELEN LARSON 8615 SEVEN LOCKS RD. BETHESDA, MD. 20034 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac failure</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerotic Cardiovascular Disease</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (d) <u>Abdominal aortic aneurysm - Dissecting Aortic Aneurysm</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 WK.
2 mo
years |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/10/79 to 1/24/79, that (I) (we) last saw the deceased alive on 1/23/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 1/24/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| C. H. LIGON | | 1814 P. & Philip Dr Olney MD 20853 | | | |
| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| CREMATION | 1/24/79 | CEDAR HILL CREM | SUITLAND, P.G. MD. | | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | | |
| W. W. Chambers 8655 Sea Cone SS | | JAN 29 1979 | Kathleen M. Heady | | |

00150-01



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 1/76
(VR A 15 (4))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02161
REG. NO. | | | |
|---|--|---|--|---|--|---|------------------------------|--|----------------------------|--|--|-----------------------------------|--|
| 1. FOR
STATE
REGISTRAR | | | | | 1. DECEASED NAME
(TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| | | | | | Jonall (NMN) SAWYER | | | | | Jan 5 79 | | 8:17P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Male | | Negro | | Dec 24 56 | | 22 YRS | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Alabama | | USA | | | | Montgomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | | Nat'l Naval Medical Center | | | | | | | | Communications | | USA | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Alabama | | Montgomery | | Hope Hull | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Rt.] Box 502 | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | ADDRESS | | | |
| Gunter (NMN) Sawyer | | | | | Mary Lee Coley | | | | | Fort Bragg, N.C. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | ADDRESS | |
| Yes | | | | | 2/2/75-1/5/79 | | Cheryl Elaine Sawyer | | | | | 66 Honeycutt | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Leukemia</u>
2080
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOT BY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>19 Dec</u> , 19 <u>78</u> , to <u>5 Jan</u> , 19 <u>79</u> , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on <u>5 Jan</u> , 19 <u>79</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>David A. Trace</u> MD
DEGREE | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
6 Jan 79 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID A. TRACE | | | | | 22e. ADDRESS
Nat'l Naval Medical Center, Bethesda, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | 11 Jan 79 | | Sawyer's Family Cemetery | | Hope Hull Montgomery Alabama | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | | ADDRESS | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Marshall Funeral Home | | | | | 4217 9th St. Wash D.C. | | JAN 11 1979 | | | | | | |

VOIDED DEATH CERTIFICATE # 79-02162

ACTUALLY 1978 DEATH

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02163
REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
John | | MIDDLE
Oscar | | LAST
Schafler | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 7, 1979 | | 2b. HOUR
11:55 PM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9-30-1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
St Louis Mo | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Kensington | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Circle Manor Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Plumber | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
14209 Northwyn Drive | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Schafler | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine Winkler | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | 17. INFORMANT
ADDRESS
William Schmultz (Same as 13e) | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
4140 DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC HEART DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ONE YEAR | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
RESPIRATORY INFECTION | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from OCT 5, 1973, to JAN 9, 1979, that (2) (we) last saw the deceased alive on JAN 5, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.) | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Martin C. Shargel | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/8/79 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARTIN C. SHARGEL | | 22e. ADDRESS
3720 FARROBUT AVE
KENSINGTON, MD - 20795 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
7 1/8/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria Virginia | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Tyson Wheeler Funeral Home, Rockville, Md. | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
JAN 10 1979 | | 25b. REGISTRAR'S SIGNATURE
T. W. McCready | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

99-05103

January 1, 1978

Robert Chaffin

John

10

Price

Price

Marquette County

Charles Anne Manning

Robertson

14209 Northwest Drive

Montgomery Silver Spring

Montgomery

Windsor

Windsor

Trade Robert

1978-01-01 (see also 1978)

1978-01-01

1978

1978

1978-01-01 (see also 1978)

x

1978-01-01

1978-01-01

1978-01-01

1978-01-01 (see also 1978)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02164
REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ANNELIES PRINS SCHUETTLER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 -23-79 | | | 2b. HOUR
7:50M | | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 05 29 | | 6. AGE (IN YEARS LAST BIRTHDAY)
49 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
HOLLAND | | 7b. CITIZEN OF WHAT COUNTRY?
Perm. Resident U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Pr. Georges | | 13c. CITY OR TOWN
Brentwood | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Gerrit Prins | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Liesbeth | | | 13e. STREET ADDRESS
3708 Windom Rd. (13e) | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
577 64 2176 | | 17. INFORMANT
ADDRESS
(as above) | | | | 17. INFORMANT
ADDRESS
(as above) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) COMA
2030
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) THROMBO CYTOPENIA & HYPERCALCAMIA
DUE TO, OR AS A CONSEQUENCE OF
(c) MULTIPLE MYELOMA | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min.
1 week
6 months | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/16 , 19 79 , to 1/23 , 19 79 , that (I) (we) last saw the deceased alive on 1/23 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
E. S. Levin | | | | | | DEGREE
ATTENDING MEDICAL STAFF
PHYSICIAN DIRECTOR PHYSICIAN | | 22c. DATE SIGNED
1/23/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Edgar H. Levin | | | | | | 22e. ADDRESS
3630 Fenton Street, Silver Spring, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | | 23b. DATE
1/26/79 | | 23c. NAME OF CEMETERY OR CREMATORY
FT. LINCOLN Crematory Brentwood, BG. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
MD | | | |
| 24. FUNERAL DIRECTOR
J.A. Walters | | | | | | 25a. DATE RECD. BY REGISTRAR
JAN 25 1979 | | 25b. REGISTRAR'S SIGNATURE
Robert McCready | | |

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RECEIVED

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(as above)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-02165 | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|-----|--|----------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | | |
| Mary A. SCHULZ | | | | | | | | 01 22 79 | | | | | 6:06AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Female | | White | | April 25, 1884 | | | | 94 YRS. | | MONTHS | | DAYS | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Maryland | | U.S.A. | | | | | | Montgomery | | | | MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Olney | | Montgomery Gen. Hospital | | | | Secretary | | U.S. Gov't. | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 25200 Frederick Rd. | | | | | | | |
| Maryland | | Montgomery | | Clarksburg | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | | | |
| John O. Haynie | | | | Louise Darby Burdette | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | | |
| No | | | | 220-46-6409 | | Mrs Otis Edelin Day, Item 13 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial infarction, suggested</u>
<u>410-</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Interventricular Heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bacterial ulcer</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21c. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>11/10</u> 19 <u>79</u> to <u>1/22</u> 19 <u>79</u> , that (1) (we) lost saw the deceased alive on <u>1/22</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | | | | | |
| <u>John Lodmell M.D.</u> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | <u>1/22/79</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | | | |
| John Lodmell, M. D. | | | | 18111 Prince Philip Dr., Olney, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY STATE | | | | | |
| Burial | | | | Jan. 24, 1979 | | Hyattstown | | Hyattstown, Montg., Md. | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Olin L. Molesworth, D.D.P.S., Md. | | | | | | | | JAN 24 1979 | | <u>Robert H. Brown</u> | | | | | |

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CITY OF LOS ANGELES

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5791, 45, 074

• *Journal of Management Education*, 2000, 24(1), 10-15

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02166
REG. NO.1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Anna | | | FIRST MIDDLE LAST Schwartz | | | 2a. DATE OF DEATH MONTH DAY YEAR Jan 15 79 | | | 2b. HOUR 5:45 P.M. | | |
| 3 SEX Female | | | 4 RACE White | | | 5 DATE OF BIRTH MONTH DAY YEAR July 4, 1889 | | | 6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | |
| 10 CITY OR TOWN OF DEATH Rockville | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fur Dealer | | | 12b. KIND OF BUSINESS OR INDUSTRY Fur | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE D. C. | | | 13b. COUNTY | | | 13c. CITY OR TOWN Washington | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Moishe | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deena | | | 13e. STREET ADDRESS 1808 Conn. Ave., N. W. #202 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 579-07-6011 | | | 17 INFORMANT ADDRESS Mrs. Lili Crane Same as No. 13 | | | | | |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPTICEMIA
2506 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
(b) GANGRENE
(c) DIABETIC ANGIOPATHY | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: SEVERE ORGANIC BRAIN SYNDROME | | | | | | | | | | | |
| 19a. DATE OF OPERATION — | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/7/79 , to 1/15/79 , that (I) (we) lost saw the deceased alive on 1/15/79 , and not in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE D. D. Patel | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1/16/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. D. PATEL | | | 22e. ADDRESS 6121 Montrose Rd. Rockville | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/17/1979 | | | 23c. NAME OF CEMETERY OR CREMATORY Mount Lebanon Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville, Maryland | | |
| 24 FUNERAL DIRECTOR NAME Donald M. Stein Hebrew Memorial F.H. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 19 1979 | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |
| 232 Carroll Street, N. W. Washington, D. C. | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02167
REG. NO. | |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>Max L. Schwartz</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>1-15-79</i> | | | 2b. HOUR
<i>7:13 PM</i> | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>Jan. 5 1913</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
<i>66</i> | | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>New York</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> | | | MD. | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Holy Cross Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Chair. of Board</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Phillips-born Cloth Store</i> | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN
<i>Md. Montgomery Potomac</i> | | | | 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13f. STREET ADDRESS
<i>10041 Chapel Road</i> | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>Louis Schwartz</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Fannie Shapiro</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>No</i> | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
<i>064-16-2122</i> | | 17. INFORMANT'S NAME AND ADDRESS
<i>Steven F. Schwartz, 45 E. 85th St. New York, N.Y. 10028</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>
410-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Myocardial infarction</i>
(c) <i>Arteriosclerotic Heart dis</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<i>Rheumatoid Arthritis</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/15/79</i> to <i>1/15/79</i> , that (I) (we) last saw the deceased alive on <i>1/15/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death.) | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Morton W Shapiro M.D.</i> | | | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>1-15-79</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Morton W Shapiro M.D.</i> | | | | 22e. ADDRESS
<i>6225 Pooks Hill Rd Bethesda</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | | | 23b. DATE
<i>1/18/1979</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>King David Cemetery</i> | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Falls Church Virginia.</i> | | |
| 24. FUNERAL DIRECTOR NAME
<i>JOSEPH CAWLER'S SONS INC.</i> | | | | ADDRESS
<i>5130 WISC. AVE., N. W. WASH., D. C. 20016</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 22 1979</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

13-05181

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. 79-02168 | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARY F. SCOTT | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1 10 79 | | | 2b. HOUR
1245 A M | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR
2 3 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ALABAMA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
7620 MAPLE AVE. #409 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DOMESTIC | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD. | | 13b. COUNTY
MONT. | | 13c. CITY OR TOWN
TAKOMA PARK | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7620 MAPLE AVE #409 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
LENN FIELDS | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
JEANNETT IVSON | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO.
214-32-9919 | | 17. INFORMANT ADDRESS
URVAN SCOTT-ALLEN SAME AS ABOVE | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma, lung
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 mo. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ASHD with history of myocardial infarct & CHF | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 19 65 , to 1-10 19 79 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 1-5 19 79 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
George H. Sengstack DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
1-10-79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GEORGIE H. SENGSTACK | | | | | | 22e. ADDRESS
9241 COLUMBIA BLVD. S.S., MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
1-13-79 | | 23c. NAME OF CEMETERY OR CREMATORY
MD National Mem. Hk. Laurel, Pr. Geo. Md. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME George R. Snowden ADDRESS 246 N. Wash. St. Rockville, MD. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1979 | | 25b. REGISTRAR'S SIGNATURE
notary already | |

88150-01

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 79-02169 | | | |
|--|--|------------------|--|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | RECORD NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
M. PETER T. SAGE SEBASTIAN | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR
1 18 19 79 | | 2b. HOUR
M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
May 1, 1955 25 | | 6. AGE (IN YEARS) MONTHS DAYS HOURS MIN
25 YRS. | | 7. IF UNDER 1 YR. IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR
1 23 19 79 | | 2d. HOUR
9:45A M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5304 Sherill Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Student | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Education | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5304 Sherill Avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Peter Sebastian | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Harvel Huddleston | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
577 80 8368 | | 17. INFORMANT
Peter Sebastian | | | | ADDRESS
U.S. DEPT OF STATE Washington DC. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). <u>Acute cocaine intoxication</u>
3042
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Margarita A. Korell</i> | | | | TITLE (SPECIFY)
M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED
1/24/79 | |
| EXAMINER'S NAME (TYPE OR PRINT)
Margarita A. Korell, M.D. | | | | ADDRESS
111 Penn St. Balto., MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | | 23b. DATE
1/27/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Alexandria Virginia | | | |
| 24. FUNERAL DIRECTOR
NOMES, P.A. BETHESDA MARYLAND | | | | 25a. DATE RECEIVED BY REGISTRAR
FEB 1 1979 | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

18-02168

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02170
REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Annie Segal | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan. 1 1979 | | 2b. HOUR
9:25 A.M. | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 25, 1885 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
93 | | IF UNDER 1 YEAR
MONTHS DAYS
YRS. | | IF UNDER 24 HRS
HOURS MIN
--- | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Lithuania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery | | 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Hebrew Home of Washington | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | | 13a. STREET ADDRESS
5225 Pooks Hill Rd. | |
| 13a. STATE
Md | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Eugene Morton Darch | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Fannie Deutsch | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | |
| 16b. SOCIAL SECURITY NO.
446-486-2 | | 17. INFORMANT
Isadore G. Aik, 5225 Pooks Hill Rd. Bethesda | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF (b) 486-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBSTRUCTIVE PULMONARY DS. | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from DEC 22 , 19 76 , to JAN 1 , 19 79 , that (I) (we) last saw the deceased alive on JAN 1 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
R. Rosenberg MD | |
| 22c. DATE SIGNED
1/1/79 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT L. ROSENBERG, MD | | 22e. ADDRESS
6121 MONTAIGNE RD, ROCKVILLE, MD 20852 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
Jan 1, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Anshe Emeth | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Skokie Ill. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Danzansky-Goldberg Inc. 1170 Rockville Pike | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1979 | |
| 25b. REGISTRAR'S SIGNATURE
Robert L. Rosenberg | | 25c. REGISTRAR'S SIGNATURE
Robert L. Rosenberg | | 25d. REGISTRAR'S SIGNATURE
Robert L. Rosenberg | |

07150-27

1

1024

BP _____
DHMH - 16 50M 7/77
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02171
REG. NO. | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | I. DECEASED NAME
(TYPE OR PRINT)
Dale Robert Seidell | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 08, 1979 | | 2b. HOUR
A
2:55 M | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
August 08, 1958 | | 6. AGE (IN YEARS LAST BIRTHDAY)
20 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Michigan | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
The Clinical Center, NIH Bethesda Md | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Student | | 12b. KIND OF BUSINESS OR INDUSTRY
College | |
| 13a. STATE
Michigan | | 13b. COUNTY
Lapeer | | 13c. CITY OR TOWN
Imlay City | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
210 Weston Street | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert A. Seidell | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elsie Sterner | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
369-66-6334 | | 17. INFORMANT
Imlay City, Michigan 48444
Mr. Robert A. Seidell, 210 Weston Street | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
<u>2002</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>BURKITT'S LYMPHOMA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>DUE TO, OR AS A CONSEQUENCE OF</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>January 03, 19 79</u> , to <u>January 08, 19 79</u> , that (2) (we) last saw the deceased alive on <u>January 08, 19 79</u> , and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above, <u>X</u> (we) did <u>XXXX</u> view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Julie Blatt MD</u> | | DEGREE
MD | | 22c. DATE SIGNED
<u>1/8/79</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JULIE BLATT MD | | 22e. ADDRESS
of Health, Bethesda, Md. 20014
The Clinical Center, National Institutes | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/11/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Imlay Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Imlay/ Lapeer Mich | | | | | |
| 24. FUNERAL DIRECTOR
NAME
W.W. Chambers Co. | | ADDRESS
8655 Ga. Ave. Sil. Sprng, Md. | | 25a. DATE REC'D. BY REGISTRAR
1/11/79 | | 25b. REGISTRAR'S SIGNATURE
<u>W. W. Chambers</u> | | | | | |

MEDICAL CERTIFICATION

79-02171

CHIEF OF BUREAU

DEPUTY CHIEF OF BUREAU

ASSISTANT CHIEF OF BUREAU

CLERK

RECORDS

TRAINING

COLLAGE

STUDENT

LABORER

STAFF

WIFE

RECEIVED

ROBERT

NO

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02172
REG. NO. | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Barbara J. SENIO | | | | 2a. DATE OF DEATH MONTH DAY YEAR
January 8 1979 | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
July 8 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY)
46 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Massachusetts | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
National Naval Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Virginia | | | | 13b. COUNTY
Fairfax | | 13c. CITY OR TOWN
Annandale | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Joseph P. Tukis | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Barbara Gureckis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT
Walter P. Senio | | ADDRESS
See item 13 | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Breast CA</u>
1749
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I/we) (this hospital) attended the deceased from <u>January 2</u> , 19 <u>79</u> , to <u>January 8</u> , 19 <u>79</u> , that (I/we) last saw the deceased alive on <u>January 8</u> , 19 <u>79</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Marina N. Vernalis Lt MC USNR | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Jan. 8 1979 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Marina N. Vernalis, M. D. | | | | 22e. ADDRESS
National Naval Medical Center, Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Arlington Va. | |
| 24. FUNERAL DIRECTOR NAME
Demaine Funeral Home | | | | ADDRESS
Annandale, Va. | | 25a. DATE REG'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | |

79-02172

| Case No. | Subject | Location | Date | Remarks |
|----------|------------------|-------------------------------|-----------------|---------|
| 79-02172 | Barbara J. | Massachusetts | January 8, 1979 | |
| | Graciano | USA | July 8, 1972 | |
| | X | | | |
| | Bartholomew | National Naval Medical Center | | |
| | Virginia Fairfax | 2017 General Court | | |
| | Joseph P. | Texas | | |
| | Barbara | Gutierrez | | |
| | Halter P. Davis | See item 12 | | |

| Case No. | Subject | Location | Date | Remarks |
|----------|------------------|-------------------------------|-----------------|---------|
| 79-02172 | Barbara J. | Massachusetts | January 8, 1979 | |
| | Graciano | USA | July 8, 1972 | |
| | X | | | |
| | Bartholomew | National Naval Medical Center | | |
| | Virginia Fairfax | 2017 General Court | | |
| | Joseph P. | Texas | | |
| | Barbara | Gutierrez | | |
| | Halter P. Davis | See item 12 | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02173
REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
<i>Elizabeth E. Seymour</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>1/14/79</i> | | | 2b. HOUR
<i>2:30 a.m.</i> | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>7 4 31</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>47</i> YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<i>England</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>England</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spr.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>University Nursing Home</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Sec. Receptionist</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Medical Office</i> | |
| 13a. STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Sil. Spring</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Alfred Millin</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Ellen Naylor</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>no</i> | | | |
| 16b. SOCIAL SECURITY NO.
(IF GIVEN, GIVE OR DATES)
<i>none</i> | | | 17. INFORMANT
ADDRESS
<i>Richard A. Seymour-husband-(same as 13e)</i> | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Ca Colon</i>
<i>1539</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3 yrs</i> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>12/29</i> , 19 <i>78</i> , to <i>1/14</i> , 19 <i>79</i> , that (we) lost
saw the deceased alive on <i>1/3</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (we) (we do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Walter G. Gough</i> | | | DEGREE
<i>MD</i> | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>1-14-79</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Walter Gough MD</i> | | | 22e. ADDRESS
<i>2309 Shorefield Wheaton, Md</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | | 23b. DATE
<i>Jan. 16-79</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Gate of Heaven</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Sil. Spring Montgomery Md</i> | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Warner Pumphrey</i> | | | ADDRESS
<i>8434 Ga. Ave SS.</i> | | | 25a. DATE REC'D. BY REGISTRAR
<i>IAN 18 1979</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Dickie McCreedy</i> | |

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "University" and "Department" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| FOR
1 - STATE
REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 79-02174
REG. NO. | |
|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John B. Shepherd | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 11 1979 | | 2b. HOUR
8:09 AM | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
9 19 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Luray, Va. | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montg. MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Washington Adventist. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Shop Foreman, Read Plastics | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland. | | 13b. COUNTY
Montg. | 13c. CITY OR TOWN
Takoma Park | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
Thomas Shepherd. | | 15. MOTHER'S MAIDEN NAME
Elizabeth Blackburn. | | 13e. STREET ADDRESS
7705 Takoma Ave. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO. | | 16b. SOCIAL SECURITY NO.
577-07-4577 | | 17. INFORMANT
Ruth R. Shepherd. (Wife) 13 e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>arteriosclerotic Cardio Vascular Dis.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>long duration</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
14 min |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Diabetes mellitus - Chronic Lymphocytic Leukemia</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/7</u> , 19 <u>78</u> , to <u>Jan 11</u> , 19 <u>79</u> , that (I) (we) lost
saw the deceased alive on <u>Jan 10</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Lawson, M.D.</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/11/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Jan 15, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | |
| 23d. LOCATION
CITY OR TOWN
Silver Spring | | COUNTY
Montg. | | STATE
Md. | |
| 24. FUNERAL DIRECTOR
NAME
TAKOMA F.H. (T.A. Walters) | | 25a. DATE REC'D. BY REGISTRAR
JAN 18 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>John M. Brady</u> | |

47150-07

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| FOR
STATE
REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 79-02175
REG. NO. | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Brian Christopher Shuma | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 22, 1979 | | 2b. HOUR
2:25 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
January 22, 1979 | | 6. AGE (IN YEARS LAST BIRTHDAY)
1 Hr. YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
None | | 12b. KIND OF BUSINESS OR INDUSTRY
None | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
David E. Shuma | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Brenda K. Hageman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | 17. INFORMANT
ADDRESS
David E. Shuma Same as 13e) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congenital Disease</u>
<u>7560</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Pierre-Robins Syndrome</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>Hydrocephalus</u>
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 hr.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-22-79</u> , 19____, to <u>1-22-79</u> , 19____, that (I) (we) last saw the deceased alive on <u>1-22-79</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Frank Mate Jr. M.D.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>1/22/79</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Frank Mate Jr. M.D. | | | | 22e. ADDRESS
50 West Edmonston Dr. Rockville, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/26/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Tyson Wheeler Funeral Home, Rockville, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 30 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Barry McCreedy</u> | |

79-05172

January 2, 1979

Continued

Page

January 2, 1979

White

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1.1.A.

JAN 10 1979

1.1.A. 1.1.A. 1.1.A.

NAME: William August Silverwood

DATE OF DEATH: January 1, 1979

PLACE OF DEATH: Montgomery County

SEE: #79-04807

February, 1979

Montgomery County

WINTER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02176
REG. NO. | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR
1- STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
LAMOYNE D SIMMONS | | | | 01 - 15 - 79 | | | | 8 52 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
JUNE 27 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
52 YRS | | IF UNDER 1 YEAR IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WEST VA. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co MD | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY
MD. PR. GEO. HYATSVILLE | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3354 TOLEDO TERRACE | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
CHARLES F. HANDSCHUMACHER | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ANNA MORRIS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
JAMES M. SIMMONS 3354 TOLEDO TER. HYATSVILLE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
486-
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/15 19 78, to 1/15 19 79, that (I) (we) last saw the deceased alive on 1/15 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Norman H. Richester MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/16/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 19, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Arlington Virginia | | | |
| 24. FUNERAL DIRECTOR NAME
Arthur Walters | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 22 1979 | | 25b. REGISTRAR'S SIGNATURE
Hector McCreedy | | | |

12-05112

Classified by Medical Examiner Dr. Royer
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 not to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | |
|---|--|--|--|--|--|--|--|--|--|
| Albert F. Sinyard | | | | January 3, 1979 | | | | 8:10PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| MALE | | WHITE | | NOV 17, 1906 | | 72 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| WASH., D. C. | | U.S.A. | | | | Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Olney | | Montgomery General Hospital | | | | WASHINGTON GAS | | LIGHT CO. | |
| 13a. STATE | | | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS | | | |
| MARYLAND | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 15401 BASSETT LANE | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| WILLIAM H. SINYARD | | | | MARGARET VIRGINIA FRALEY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | | | 577-07-7956 | | LAURA E. SINYARD SAME AS 13 WIFE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Myocardial infarction | | | | | | | | | |
| 410 - DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) Severe occlusive arterial disease | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | | | P.M. | | 19 | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | |
| Geoffrey M. Wilner, MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 1/4/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| GEOFFREY M. WILNER | | | | Montgomery General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. STATE | |
| BURIAL | | 1/6/79 | | FT. LINCOLN CEMETERY | | BRENTWOOD | | PRI GEO MD. | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| FRANCIS J. COLLINS | | | | JAN 10 1979 | | [Signature] | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | |

72-05177

APR 17 1964

WHITE

WIFE

XX

U.S.A.

WIFE, D.C.

WASHINGTON GAS LIGHT CO.

1301 BASSETT LANE

MARYLAND MONTGOMERY SILVER SPRING X

TRALEY

MIRGUNA

MARGARET

STWARD

WILLIAM

WIFE

SALE AS IS

LADY E. STWARD

527-07-7226

NO

500 JOHN KENNEDY BLVD. SILVER SPRING, MD. 20901

FRANKS & COLLINS

11/1/79

FT. LINCOLN CEMETERY

MD. GEN.

82-05178

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02179
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LILLIE Mae SKYLES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 18 1979 | | | 2b. HOUR
2:30 P.M. | | | |
| 3. SEX
Female | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
January 2 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY)
47
YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Naval Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS
Pennsylvania Philadelphia YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 7701 Lindberg Blvd. | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNK | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Thomas | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
257 26 9920 | | 17. INFORMANT
ADDRESS
Mr. Leon Skyles See Item 13 | | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC BREAST CANCER
1749
DUE TO, OR AS A CONSEQUENCE OF (b) BREAST CANCER
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 20 19 78 to Jan. 18 19 79, that (I) (we) lost
saw the deceased alive on Jan. 18 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
James J. Curran | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Jan. 19 1979 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CURRAN JAMES J | | | | 22e. ADDRESS
National Naval Medical Center, Bethesda, Md. | | | |

| | | | | | | | |
|--|--|---------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
REMOVAL | | 23b. DATE
JAN 19, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
GEORGE RAY FUNERAL HOME | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
PHILADELPHIA PA. | |
| 24. FUNERAL DIRECTOR
NAME
Alexander S. Pope Funeral Home | | | | ADDRESS
Washington, D.C. | | 25a. DATE REC'D. BY REGISTRAR
JAN 25 1979 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2521 01 .ast x

National Level Medical Council, Bethesda, Md.

24092

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or ~~filled in~~ to show any injury, or other traumatic event, the medical examiner must be notified at once.

Released by Dr. Mayfield

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02180 | |
|--|--|---|--|---|--|--|-------------------------------|--|--|---|--|
| FOR
1. STATE
REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) Roy ROY C Slaughter | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 1-26-79 | | 2b. HOUR
5:15 P. M. | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR April 18 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 1 HRS
HOURS MIN. | |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)
Indiana | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Self-Employed | | 12b. KIND OF BUSINESS OR INDUSTRY
Insurance | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Potomac | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
11053 Powder Horn Drive | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Roy Slaughter | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO.
WW1 | | 17. INFORMANT
ADDRESS
Patricia H. Slaughter, Wife. Same as item 13. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
410-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Coronary atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) years | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 3:30 19 79 , to 2:00 19 79 , that (he/she) lost saw the deceased alive on 3:30 19 79 , and that (we) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Joseph J. Daum | | | | DEGREE
MD | | | | 22c. DATE SIGNED
27 Jan 79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOSEPH J. DAUM | | | | 22e. ADDRESS
7505 Democracy Dr. Bethesda, Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
1/30/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
JOSEPH CAWLER'S SONS INC. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 31 1979 | | | | 25b. REGISTRAR'S SIGNATURE
Jeffrey M. Brady | | | |

79-05180

STANDARD

BOY

Boy

25

April 19 1938

White

Male

X

11-2-11

Insurance

Self-employed

Hospital

11-2-11

Income

100%

100%

Unknown

Unknown

Daughter

Boy

11-2-11

11-2-11

11-2-11

11-2-11

11-2-11

11-2-11

11-2-11

11-2-11

11-2-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|---|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR (FLORENCE Lillian Smith) | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Florence Lillian Smith | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2-2-79 | | 2b. HOUR
2:04 AM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
May 29, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Harford Co. Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Retail Clothing | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Harford Co. | | 13c. CITY OR TOWN
Bel Air | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Jacob Gladden Bailey | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Rachel Mary Scarborough | | | 13e. STREET ADDRESS
319 Matland Street | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
216-20-2742-A | | 17. INFORMANT (Name) I-452-532 ADDRESS
Mrs. Theresa I. Green 4938 Clermont Mill Rd., Box 114 Pylesville, Md. 21132 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
410- DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cholesterol heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Smoking | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 19 75, to 2/2/79, that (I) (we) lost saw the deceased alive on 2/2 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Thos G. Ward | | | | DEGREE
ATTENDING PHYSICIAN | | MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/2/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thos G. Ward | | | | 22e. ADDRESS
6116 Robinson, Bethesda Md 20814 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Feb. 5, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Darlington Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Darlington, Harford Co., Maryland 21034 | | | |
| 24. FUNERAL DIRECTOR
Joseph William Foster
Superior Funeral | | | | W. Broadway & Williams St.
Bel Air, Maryland 21014 | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1979 | | 25b. REGISTRAR'S SIGNATURE
Hester McCreedy | |

18150-05

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02182

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
J. WILMER SMITH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan. 1, 1979 | | | 2b. HOUR
3:40 AM | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept 9 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6507 Greyswood Rd. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Architect | | 12b. KIND OF BUSINESS OR INDUSTRY
Architecture | |
| 13a. STATE
Md. | | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Roger B. Smith | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marian Boswell | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWI | | 17. INFORMANT
ADDRESS
Donald K. Smith (Same as 13e) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Dehydration, metabolic acidosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Metastatic bladder carcinoma</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1889 | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
± 3 min.
± 2 wks.
± 12 mo. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Arteriosclerotic heart disease, Emphysema</u> | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>July</u> , 19 <u>73</u> , to <u>Jan 1</u> , 19 <u>79</u> , that (we) lost above the deceased alive on <u>Dec 20</u> , 19 <u>78</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>James R. Moore Jr.</u> MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-1-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James R. Moore Jr. | | | | 22e. ADDRESS
207 Brookes Ave Gaithersburg, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
1-4-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Md. | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Robert A. Pumphrey</u> | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 1 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02183
REG. NO. | | | | | |
|--|--|--|--|---|--|---|--|--|--|-------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
JOHN R. SMITH SR. | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1-14-79 | | | | 2b. HOUR
7:50 P.M. | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH MONTH DAY YEAR
6-21-03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA, MD. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Insurance Sales | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN
Md. Montg. Suburban | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
733 Sligo Ave. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Henry W. Smith | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Jane Reynolds | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
578-05-0434 | | 17. INFORMANT ADDRESS
GERRY H. Smith 3916 Minden Rd. Wheaton Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>
2070
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Bilateral Bronchopneumonia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) <u>Erythro Leukemia</u>
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 mins.</u>
<u>2 weeks</u>
<u>2 months</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
2-9-79 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
CITY OR TOWN
COUNTY
STATE | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>June 6, 1974</u> , to <u>1-14, 1979</u> , that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | |
| 22b. SIGNATURE
John F. Tauber | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1-15-79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John F. Tauber | | 22e. ADDRESS
8218 Wisconsin Ave Bethesda Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/18/79 | | 23c. NAME OF CEMETERY OR CREMATORY
George Washington | | 23d. LOCATION
CITY OR TOWN
COUNTY
STATE
P.O. Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert G. Humphrey | | ADDRESS
Furnal Arms Pl Rockville Md. | | 25a. DATE REC'D BY REGISTRAR
JAN 22 1979 | | 25b. REGISTRAR'S SIGNATURE
Mary [Signature] | | | | | |

72-05183

8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP. _____
AH-1650M7/77
(VR A 15 (4))

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02184
REG. NO. | |
|--|--|--|--|---|--|--|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Minnie L. Smith | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
01 06 79 | | | 2b. HOUR
4:45pm | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
01 18 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81
YRS. | | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Domestic | | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | |
| 13a. STATE
Md. | | | | | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
Cocksville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Dorsey | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Leanna Smith | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
— | | 17. INFORMANT
Norman Smith | | 18. ADDRESS
Westminster Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>MVOCARDIAL INFARCTION</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ASHD. HCD</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
10 MINUTE
12/27/78
— | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/27, 1978, to 1/6, 1979, that (I) (we) lost
saw the deceased alive on 1/6, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/6/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GREGORIO Koss | | | | 22e. ADDRESS
13 E DEER PARK DR. CATHERSVILLE | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | |
| Burial | | 1-18-79 | | Buckley Park Cemetery | | | Cocksville Howard Md | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
HARRIS BARKER S. HARRIS | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

79-02184

48150-02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02185
REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|------------------------------------|---|--------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | MONTH DAY YEAR | | | | | |
| Russell O Smith | | | | | | 01 07 79 320 P M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | | |
| Male | | White | | Dec. 29, 1903 | | 75 YRS. | | MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | USA | | | | Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda | | Suburban Hospital | | | | Ret. Supert. 4 | | H Center | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | |
| Maryland | | | Montgomery | | | Chevy Chase | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13e. STREET ADDRESS | | | | | |
| David L. Smith | | | Rachel (Yonker) | | | 7100 Connecticut Ave. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| No | | | 220-10-0707 | | | Nola Smith, Washington, D.C. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 410- DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | 3 HR | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 1</u> , 19 <u>1978</u> , to <u>OCT 78</u> , 19 <u>78</u> , that (I) (we) lost saw the deceased alive on <u>OCT</u> , 19 <u>78</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| Ralph M. Coan M.D. | | | M.D. | | | | | 1/7/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | |
| RALPH M. COAN M.D. | | | 4400 EAST WEST HWY | | | BETHESDA, MD 20814 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | |
| Burial | | | Jan. 9, 1979 | | Piney Plains Cem. | | Flinstone, Allegany, Md. | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Kight Funeral Home, Cumberland, Maryland | | | JAN 16 1979 | | | | | | | | |

released by Dr. Bull

5400 BP

19-05182



Russell

C

Smith

01 07 19

0

Montgomery

Suburban Hospital

Bedford



(See Turner) Smith

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02186
REG. NO.1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIAM SMITH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JAN. 3, 1979 | | | 2b. HOUR
9am M | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 24, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ALABAMA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1913 BRIGGS CHANEY ROAD, | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY
GOV'T. | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1913 BRIGGS CHANEY ROAD | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
unknown Smith | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
578-07-4423 | | 17. INFORMANT
ADDRESS BANHAM, MARYLAND
BENJAMES SMITH/SON/7940 DELLWOOD AVENUE, | | | | | |

MEDICAL CERTIFICATION

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cor Congestive Heart failure
4280
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF (b) - C -
DUE TO, OR AS A CONSEQUENCE OF (c) - C - | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12-9-78 to death |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Severe atherosclerotic vascular disease

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION
- C - | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- C - | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE-FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 12-9 , 19 78 , to Jan 4 , 19 79 , that (1) (we) last saw the deceased alive on Jan-1-79 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Charles L Franklin Jr | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-4-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles L Franklin Jr | | | | 22e. ADDRESS
11218 Lockwood Dr Silver Spring Md | | | |

| | | | | | | | |
|--|--|----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
JAN. 6, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
HARMONY CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
LANDOVER PG MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME COLLINS FUNERAL HOME, INC.
ADDRESS 4339 HUNT PLACE, N. E. WASHINGTON, D.C. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

20150-05



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02187

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Kenneth M. Smoyer, Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 19, 1979 | | | 2b. HOUR
11:10p | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 2, 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales Rep. | | 12b. KIND OF BUSINESS OR INDUSTRY
Shoe | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4628 Cherry Valley Drive | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ethelbert H. Smoyer | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hannah Goodman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
194-12-6205 | | 17. INFORMANT
ADDRESS
Mary R. Smoyer, Same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hepatic Encephalopathy</u>
5712
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Cirrhosis, Alcoholic type</u>
(c) <u>Alcoholism</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u>
<u>10 years</u>
<u>20 years</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Rupture esophagus</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION
1/14/79 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Rupture esophagus | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-3</u> 19 <u>79</u> , to <u>1-19</u> 19 <u>79</u> , that (he) (we) lost saw the deceased alive on <u>1-19</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Michael D. Sulkin</u> | | | | DEGREE
<u>MD</u> | | | | 22c. DATE SIGNED
1-19-79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael D. Sulkin | | | | 22e. ADDRESS
18111 Prince Philip Drive
Olney, MD 20832 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1-23-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Maryland | | | | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT A. PUMPHREY FUNERAL
HOMES, P. A., Bethesda, Maryland | | | | | | 25a. DATE OF REGISTRATION
JAN 24 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Robert A. Pumphrey</u> | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

18150-05181

18150-05181

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02188
REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|--|---------------------------------------|---|---|--|-----------|--------------|-------------------|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
ASA | MIDDLE
CLARK | LAST
SNYDER JR | 2a. DATE OF DEATH | MONTH
JANUARY | DAY
01 | YEAR
1979 | 2b. HOUR
855 A |
| 3 SEX
MALE | 4 RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH
JULY
DAY
07
YEAR
1926 | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS. | 7a. BIRTHPLACE (STATE OR FOREIGN
COUNTRY)
WASHINGTON DC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10 CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NATIONAL NAVAL MEDICAL CENTER | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U.S. NAVY | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY
ST MARYS | 13c. CITY OR TOWN
PINEY POINT | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
28 STARK DRIVE | | | | | | |
| 14 FATHER'S NAME
FIRST
ASA
MIDDLE
CLARK
LAST
SNYDER SR | | 15 MOTHER'S MAIDEN NAME
FIRST
EVELYN
MIDDLE
NMN
LAST
BURGESS | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1942-1955 | | 17. INFORMANT
MYTLE SNYDER BOX 163 PINEY POINT, MD | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ASYSTOLE
DUE TO, OR AS A CONSEQUENCE OF
(b) CARDIAC ARREST WITH ANOXIC BRAIN DAMAGE
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(# EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DEC 27 , 19 78 , to JAN 1 , 19 79 , that (I) (we) lost
saw the deceased alive on JAN 1 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Tom Allen M.D.</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
JAN 1, 1979 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
TOM ALLEN M.D. | | 22e. ADDRESS
NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
1-4-1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Natl Cem. | | 23d. LOCATION
CITY OR TOWN
Arlington | | COUNTY
Virginia | | STATE | |
| 24. FUNERAL DIRECTOR
NAME
IVES FUNERAL HOME ARLINGTON, VIRGINIA | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

MEDICAL CERTIFICATION

88150-27

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02189
REG. NO.1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Irma L. Sobel | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1/7/79 | | 2b. HOUR
10:15 P.M. | | | | |
| 3 SEX
Female | | 4 RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Mar. 18, 1896 | | 6 AGE (IN YEARS LAST BIRTHDAY)
82 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Louisiana | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Randolph Hills Nursing Home | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MD. | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Kensington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
9900 E. Bexhill Dr. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Abe Leveson | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emily Lucas | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
436-36-7142A | | 17 INFORMANT
ADDRESS
Gloria S. Bennett Same as 13 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Card. pulmonary arrest
4275
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the registrar) attended the deceased from August, 1978 to January 1979 , that (I) was last saw the deceased alive on December 1978 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Alexander C. Chester</i> | | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
1/8/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Alexander Chester, M.D. | | | | | 22e. ADDRESS
3301 New Mexico Ave., N.W., Washington, D.C. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
Jan. 9, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Va. | | |
| 24 FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 11 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

90

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-02190 | |
|---|--|---|---|---|--|--|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) AARON L. SOLOMON | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 - 19 - 79 | | | 2b. HOUR 2:22 A.M. | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 22, 1895 | | 6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Roumania | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer | | 12b. KIND OF BUSINESS OR INDUSTRY Printing | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13a. STATE Maryland | | | 13b. COUNTY Montgomery | | | 13c. CITY OR TOWN Rockville | | |
| 14. FATHER'S NAME Unknown | | | 15. MOTHER'S MAIDEN NAME Unknown | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 6111 Montrose Road, #910 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. WW-1 166-01-4107 | | | 17. INFORMANT Robert Solomon | | | 17 ADDRESS 12115 Arbie Road Silver Spring, Maryland | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE & CARDIO-RESPIRATORY ARREST
0389
DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE METABOLIC ACIDOSIS - SEVERE
DUE TO, OR AS A CONSEQUENCE OF (c) PROBABLE SEPSIS | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 HOURS
24 HOURS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1-5 19 79 to 1-19 19 79 , tho (1) (we) lost saw the deceased on 1-18 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Robert L. Rosenberg, MD | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1-19-79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert L. Rosenberg, MD | | | 22e. ADDRESS 6121 Montrose Rd, Rockville, MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | | 23b. DATE 1/21/1979 | | 23c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia | | | |
| 24. FUNERAL DIRECTOR NAME Donald M. Stein | | | 24b. ADDRESS Hebrew Memorial F.H. | | | 25a. DATE REC'D. BY REGISTRAR JAN 24 1979 | | 25b. REGISTRAR'S SIGNATURE Lirky Roberts | | | |
| 23e. ADDRESS 232 Carroll Street, N. W. Washington, D. C. | | | | | | | | | | | |

00150-05



#14, Film G529 3/23/79 kam
 FOR
 1 - STATE
 REGISTRAR
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

79-02191
 REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) DORA SPECTOR | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-18-79 | | 2b. HOUR
4A M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 10, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Merchant | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Maryland | 13b. COUNTY
Prince Geo. | 13c. CITY OR TOWN
Langley Park | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
1024 University Blvd. East | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Solomon Pesach Levy | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Judith (Unknown) | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
150-36-3975 KI | | 17. INFORMANT
Nathan Spector ADDRESS
6121 Montrose Road Rockville, Maryland | |

| | | | | | |
|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary edema
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF
(c) atherosclerosis | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
severe chronic lung disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-16-1979 to 1-18-1979 , that (I) (we) lost saw the deceased alive on 1-18-1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
H. B. Baker | | DEGREE | | 22c. DATE SIGNED
1-18-78 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HADI BAHAR | | 22e. ADDRESS
8218 Wisconsin Avenue Bethesda | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SEE IF)
Burial | | 23b. DATE
1/19/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
National Capitol Hebrew Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D. C. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Donald M. Stein Hebrew Memorial F. H. | | 25a. DATE REC'D. BY REGISTRAR
JAN 22 1979 | | 25b. REGISTRAR'S SIGNATURE
Jeffrey McCready | |
| 232 Carroll Street, N. W. Washington, D. C. | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10150-05101

DEPT. OF AGRICULTURE

UNITED STATES GOVERNMENT

WASHINGTON, D. C.

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

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Items 15, 16 b 528 2/8/79 gj

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02192

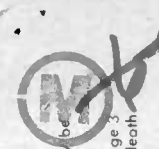
REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
KENNETH MARTIN STANNER | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 21 79 | | 2b. HOUR
9 P. | |
| 3. SEX
Male | 4. RACE
Caucasion | 5. DATE OF BIRTH
MONTH DAY YEAR
5 24 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Minnesota | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Printer-Sel. Ser. U.S. Govt | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spr., |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Bernard Stanner | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
Nellie Bannan | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
319-61-5169 | | 17. INFORMANT
ADDRESS
Louise M. Stanner 9119 Manchester Rd. Silver Spring, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RENAL FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC VASCULAR DISEASE
(c) DIABETIC NEPHRO SCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS LONG STANDING - RIGHT HE MILDNESS HYPERTENSIVE AND ARTERIO SCLEROTIC HEART DISEASE + PERIPHERAL OBSTRUCTIVE DISEASE | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, IF NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: DIABETES MELLITUS LONG STANDING - RIGHT HE MILDNESS HYPERTENSIVE AND ARTERIO SCLEROTIC HEART DISEASE + PERIPHERAL OBSTRUCTIVE DISEASE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 21 , 19 78 , to JAN 21 , 19 79 , that (I) (we) last saw the deceased alive on JAN 21 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Robert L. Kreichmar | | DEGREE
MD | | 22c. DATE SIGNED
1/21/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT L. KREICHMAR | | 22e. ADDRESS
7733 MANSK AVE N.W. WASHINGTON D.C. 20018 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/24/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cem. Silver Spring, Mont. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Warner E. Pumphrey, Inc. Sil. Spr., Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 26 1979 | | 25b. REGISTRAR'S SIGNATURE | |

28-05185

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|----|----|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| [Faint, mostly illegible text and markings throughout the form, including what appears to be a signature in the lower right section.] | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death, page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-02193

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Harry Edward Steingrebe Sr.</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR <i>1/15/79</i> | | | 2b. HOUR
MIN <i>5:45 A.</i> | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR <i>FEB 17, 1892</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
8401 WOODCLIFF COURT | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BOOKBINDER | | 12b. KIND OF BUSINESS OR INDUSTRY
GPO | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
8401 WOODCLIFF COURT | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
EDWARD STEINGREBE | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CHRISTINE ROOSCHE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW I | | 17. INFORMANT
HARRIET M. STEINGREBE | | ADDRESS
SAME AS 13 WIFE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>malnutrition</i>
4370
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Senile Dementia</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Cerebral arteriosclerosis</i> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>1 week</i>
<i>4 mos.</i>
<i>5 years</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.
<i>Emphysema + Bronchiectasis of left lung</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>28 Dec. 1955</i> , to <i>15 Jan. 1979</i> , that (I) (we) last saw the deceased alive on <i>7 Dec. 1978</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Russell B. Arnold M.D.</i> | | | | | | DEGREE
<i>M.D.</i> | | 22c. DATE SIGNED
<i>1/15/79</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Russell B. Arnold M.D.</i> | | | | | | 22e. ADDRESS
<i>1106 Spring Street Silver Spring, Md. 20910</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
<i>1/17/79</i> | | 23c. NAME OF CEMETERY OR CREMATORY
FORT LINCOLN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BRENTWOOD PRI GEO MD. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
FRANCIS J. COLLINS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>F. J. Collins</i> | |

19-05193

| | | | | | |
|---------------|-------------|---------------|----------------------|-------------|-----|
| WES | AM 1 | 125-10-1252 | HARRIET M. STEINBERG | 2000 W 12 | 125 |
| EDWARD | STEINBERG | CHRISTINE | ROSCOE | | |
| WALTON | WINTERBURY | SILVER SPRING | X | 125-10-1252 | |
| SILVER SPRING | 125-10-1252 | ROSCOE | ROSCOE | | |
| WES | AM 1 | 125-10-1252 | HARRIET M. STEINBERG | 2000 W 12 | 125 |

| | | | | | |
|---------------|-------------|---------------|----------------------|-------------|-----|
| WES | AM 1 | 125-10-1252 | HARRIET M. STEINBERG | 2000 W 12 | 125 |
| EDWARD | STEINBERG | CHRISTINE | ROSCOE | | |
| WALTON | WINTERBURY | SILVER SPRING | X | 125-10-1252 | |
| SILVER SPRING | 125-10-1252 | ROSCOE | ROSCOE | | |
| WES | AM 1 | 125-10-1252 | HARRIET M. STEINBERG | 2000 W 12 | 125 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 50M 7/77
(VRA 15 (4))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02194
REG. NO. | |
|---|--|---|--|---|--|--|--|--|-----------------------|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Stacey Erika Steward | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1-17-79 | | | 2b. HOUR
4:38 P.M. | | |
| 3. SEX
Fe | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
1 17 79 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. 0 DAYS 4 MIN. 55 | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS
HOURS 4 MIN. 55 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
NA | | 12b. KIND OF BUSINESS OR INDUSTRY
NA | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY PG 13c. CITY OR TOWN Hyattsville | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3634 Dean Dr. #N-5 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Vincent Mark Adams | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Diana Lee Steward | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
NA | | 17. INFORMANT ADDRESS
Diana Steward 3634 Dean Dr. Hyattsv., MD | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMOTHORAX - ? HEMOTHORAX ; SHOCK
7621
DUE TO, OR AS A CONSEQUENCE OF
(b) RESPIRATORY DISTRESS
DUE TO, OR AS A CONSEQUENCE OF
(c) ABRUPTIO PLACENTA
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 hrs. 55 min. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from 12:15 PM on 1/17, 19 79, to 4:38 PM on 1/17, 19 79, that (I) (we) last saw the deceased alive on 1/17, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Dr. A. Perez | | | | | | DEGREE
MD | | 22c. DATE SIGNED
1/17/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. A. PEREZ | | | | | | 22e. ADDRESS
WASHINGTON ADVENTIST HOSPITAL
TAKOMA PARK, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | | 23b. DATE
1-18-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Washington Adv. Hosp | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Takoma Pk. Montgomery MD | |
| 24. FUNERAL DIRECTOR
NAME Charley Eldridge ADDRESS WAH 7600 Carroll Ave | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 30 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

BP

18-05184

RECEIVED

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | 79-02195
REG. NO. | | | |
|---|--|------------------|--|---|--|--|--|---|--|--|--|---|--|-----------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Selma Strauss | | | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> 1/31 1979 | | 2b. HOUR
M A | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 7, 1891 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 87 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
1/31 1979 | | 24. HOUR
11:25 A. M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Germany | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Fairland Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY
----- | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
13201 Collingwood Road | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Levi ----- Oppenheim | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Zillie ----- Klein | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
----- | | 17. INFORMANT
ADDRESS
Lore Nirnbaum, 13201 Collingwood Rd. Sil Spg., Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
4140
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) <u>arteriosclerotic heart disease.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) -----
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
<u>Fracture of right hip.</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION
12/26/78 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
Fracture of right hip. | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
XX 12/12 1978 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
Fell at home. | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Collingwood Rd., Silver Spring, Mont., Md. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> | | | | TITLE (SPECIFY)
M.D. Deputy | | | | MEDICAL EXAMINER
DATE SIGNED 1/31/79 | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) John S. Rogers, M.D. | | | | ADDRESS
1919 Seminary Road
Silver Spring, Montgomery, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | | 23b. DATE
2-1-79 | | 23c. NAME OF CEMETERY OR CREMATORY
G.W. Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hyattsville, PrGeo., Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME Danzansky-Goldberg Chapels | | | | ADDRESS
Rockville, Md.
1170 Rockville Pike | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>Hefny McCreedy</i> | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

20150-02

MEMO FOR THE RECORD
SUBJECT: [Illegible]
DATE: [Illegible]





| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02196
<small>REG. NO.</small> | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<div style="text-align: center; font-size: 1.2em;">HANNAH STRINGER</div> | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<div style="text-align: center; font-size: 1.2em;">JAN 17 1979</div> | | 2b. HOUR
<div style="text-align: center; font-size: 1.2em;">2 A</div> | | | | | | | | | |
| 3 SEX
<div style="text-align: center; font-size: 1.2em;">Female</div> | | 4 RACE
<div style="text-align: center; font-size: 1.2em;">Caucasian</div> | | 5. DATE OF BIRTH MONTH DAY YEAR
<div style="text-align: center; font-size: 1.2em;">August 10 1907</div> | | 6 AGE (IN YEARS LAST BIRTHDAY)
<div style="text-align: center; font-size: 1.2em;">71</div> | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<div style="text-align: center; font-size: 1.2em;">Mexico</div> | | 7b. CITIZEN OF WHAT COUNTRY?
<div style="text-align: center; font-size: 1.2em;">U.S.A.</div> | | | | | | | | | |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<div style="text-align: center; font-size: 1.2em;">Mexico</div> | | 7b. CITIZEN OF WHAT COUNTRY?
<div style="text-align: center; font-size: 1.2em;">U.S.A.</div> | | 8 <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> WIDOWED | | 9 BALTIMORE CITY OR COUNTY OF DEATH
<div style="text-align: center; font-size: 1.2em;">Montgomery MD.</div> | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<div style="text-align: center; font-size: 1.2em;">Bethesda</div> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
<div style="text-align: center; font-size: 1.2em;">Suburban Hosp.</div> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<div style="text-align: center; font-size: 1.2em;">Homemaker</div> | | 12b. KIND OF BUSINESS OR INDUSTRY
<div style="text-align: center; font-size: 1.2em;">Home</div> | | | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13a. STATE
<div style="text-align: center; font-size: 1.2em;">Maryland</div> | | 13b. COUNTY
<div style="text-align: center; font-size: 1.2em;">Montgomery</div> | | 13c. CITY OR TOWN
<div style="text-align: center; font-size: 1.2em;">Kensington</div> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<div style="text-align: center; font-size: 1.2em;">10225 Kensington Pky.</div> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<div style="text-align: center; font-size: 1.2em;">William Melson</div> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<div style="text-align: center; font-size: 1.2em;">Mary E. Foster</div> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<div style="text-align: center; font-size: 1.2em;">No</div> | | | | | | | | 16b. SOCIAL SECURITY NO.
<div style="text-align: center; font-size: 1.2em;">N/A</div> | | 17. INFORMANT ADDRESS
<div style="text-align: center; font-size: 1.2em;">Steens, Mississippi
Mrs. Lydia Davis, Rt. 1, Box 202</div> | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiac arrest. | | | | | | | | | | | | | | | | | | | |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) Pulmonary Edema. | | | | | | | | | | | | | | | | | | | |
| UNDERLYING CAUSE (c) Bronchopneumonia | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<div style="text-align: center; font-size: 1.2em;">P.M. 19</div> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE
<div style="text-align: center; font-size: 1.2em;">Columbus, Mississippi</div> | | | | | | | | | | | | | |
| | | 22a. I certify that (I) (this hospital) attended the deceased from 1-15 , 19 79 , to 1-15 , 19 79 , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<div style="text-align: center; font-size: 1.5em;">Christopher Unger</div> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
<div style="text-align: center; font-size: 1.2em;">1-18-79</div> | | | | | | | | | | | |
| | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<div style="text-align: center; font-size: 1.2em;">Dr. Christopher Unger</div> | | | | | | 22e. ADDRESS
<div style="text-align: center; font-size: 1.2em;">7801 Moorland Lane, Bethesda, MD</div> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<div style="text-align: center; font-size: 1.2em;">Burial</div> | | 23b. DATE
<div style="text-align: center; font-size: 1.2em;">1-20-78</div> | | 23c. NAME OF CEMETERY OR CREMATORY
<div style="text-align: center; font-size: 1.2em;">Memorial Gardens</div> | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<div style="text-align: center; font-size: 1.2em;">Columbus, Mississippi</div> | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
<div style="text-align: center; font-size: 1.2em;">Roderic A. Pumphrey Funeral Homes, P.A.
7557 Wisconsin Ave., Bethesda, Maryland</div> | | | | | | 25a. DATE REC'D. BY REGISTRAR
<div style="text-align: center; font-size: 1.2em;">JAN 24 1979</div> | | 25b. REGISTRAR'S SIGNATURE
<div style="text-align: center; font-size: 1.2em;">[Signature]</div> | | | | | | | | | | | |

80150-05

15

JAN 2 1972

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02197
REG. NO.

| | | | | | | |
|---|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GERTRUDE B. SWEENEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JANUARY 9, 1979 | | 2b. HOUR
3:18 PM | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPT 27, 1930 | | |
| 6 AGE (IN YEARS LAST BIRTHDAY)
48 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | 10 CITY OR TOWN OF DEATH
ROCKVILLE | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
16509 CAVALRY DRIVE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
REGISTERED NURSE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
GEORGE J. BAILEY | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELEANOR KOSLOSKY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
173-24-9276 | | 17 INFORMANT
ADDRESS
BERNARD P. SWEENEY SAME AS 13 HUSBAND | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the Breast with Metastases
1749
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from May 1975 , to January 1979 , that (I) (we) lost
saw the deceased alive on January 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Israel Spector MD | | DEGREE
MD | | 22c. DATE SIGNED
1/10/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Israel Spector MD | | 22e. ADDRESS
911 Silver Spring Avenue SS MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
1/12/79 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | 24 FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS
ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD, 20901 | | | | |
| 25a. DATE REC'D. BY REGISTRAR
JAN 12 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | |

10-05101



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02198

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HATTE ELIZABETH. TATE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JAN 29 79 | | | 2b. HOUR
8:30 AM | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 22 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co MD. | | | |
| 10. CITY OR TOWN OF DEATH
Poolesville Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
19325 Hempstone | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. 13b. COUNTY Montg. 13c. CITY OR TOWN Poolesville | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
19325 Hempstone | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ji King RAUGH | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CARRIE Emeigh | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
195-30-4506 | | 17. INFORMANT
ADDRESS
Mr. Gearhart - 19325 Hempstone Poolesville | | | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial Infarction
410-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) ARTERIOSCLEROTIC cardio
(c) Vascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
INSTANT.
years | |
|--|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Diabetes Mellitus

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from **JAN 15**, 19 **79**, to **JAN 29**, 19 **79**, that (I) (we) lost
saw the deceased alive on **JAN 15 79**, 19 **79**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 22b. SIGNATURE
Delwitt E. DeLaster MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
JAN 29, 1979 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Delwitt E. DeLaster, MD | | 22e. ADDRESS
5500 Friendship Blvd Chevy Chase Md 20015 | | | | | |

| | | | | | | | |
|--|--|----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/1/79 | | 23c. NAME OF CEMETERY OR CREMATORY
CARSON Valley Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Allegheny Township BLAIN PA. | |
|--|--|----------------------------|--|---|--|---|--|

| | | | | | | | |
|---|--|-----------------------------------|--|--|--|--|--|
| 24. FUNERAL DIRECTOR
NAME
W. C. Helter | | ADDRESS
Barnesville Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 7 1979 | | 25b. REGISTRAR'S SIGNATURE
Anthony McElroy | |
|---|--|-----------------------------------|--|--|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

18-05188

(18)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02199
REG. NO. | |
|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) CORA M. Thackston | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-27-79 | | 2b. HOUR
1:45 P M |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 12, 1893 | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., D.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery City MD. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda, Md. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Bookkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY
Oil Co. |
| 13a. STATE
Md. | | 13b. COUNTY
Montg. | 13c. CITY OR TOWN
Bethesda | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
6013 Walton Rd. |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter Magruder | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie Quackenbush | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
578-46-6783 | | 17. INFORMANT
ADDRESS
A Edward M. Thackston Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pneumonia, exp. arrest
496-
DUE TO, OR AS A CONSEQUENCE OF
(b) COPD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 1-26 , 19 79 , to 1-27 , 19 79 , that (we) lost saw the deceased alive on 1-26-79 , 19 79 , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Franke Westphal M.D. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1-27-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Franke Westphal | | | 22e. ADDRESS
809 Veirs Mill Rd. Rockville, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 30, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md. | | 25a. DATE RECEIVED BY REGISTRAR
FEB 1 1979 | | | |
| 25b. REGISTRAR'S SIGNATURE
Anthony McCreedy | | | | | |

BP

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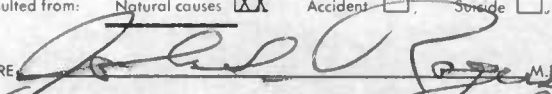
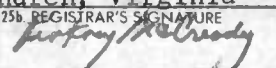
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• • •

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 79-02200

| | | | | | | | | | | | | |
|--|------------------|--|--|---|--|---|--|---|--|---|--|-----------------------|
| 1. FOR
STATE
REGISTRAR | | 2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1/27 1979 | | | | | | | | | | 2b. HOUR M 10:26 A. M |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Clara | | MIDDLE
----- | | LAST
Tralinsky | | | | | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR Jul. 20, 1902 | | 6. AGE (IN YEARS
LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | 7c. DATE
PRONOUNCED DEAD 1/27 1979 | | 7d. HOUR A. M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | | | | | | MD. |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1220 East West Highway, #172 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
----- | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1220 East West Highway, #172 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jacob ----- Stein | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
(unknown) | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
----- 261-88-2441 | | 17. INFORMANT
Stanley M. Tralins, | | ADDRESS
Kensington, Md.
4526 Saul Rd. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. }
(b) <u>chronic myocardial disease.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Years | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
None | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
None | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
M.D. Deputy | | MEDICAL EXAMINER
1919 Seminary Road | | DATE SIGNED
1/27/79 | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
John S. Rogers, M.D. | | ADDRESS
Silver Spring, Montgomery, Md. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1-29-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Nat'l. Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church, Virginia | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Chapels, | | ADDRESS
Rockville, Md.
1170 Rockville Pike | | 25a. DATE REC'D. BY REGISTRAR
FEB 1 1979 | | 25b. REGISTRAR'S SIGNATURE
 | | | | | | |

BP

13-05500

OPTIONAL FORM NO. 10, MAY 1962 EDITION

PREPARED BY THE NATIONAL ARCHIVES

FOR THE NATIONAL ARCHIVES

RECORDS MANAGEMENT DIVISION

WASHINGTON, D.C. 20540

U.S. GOVERNMENT PRINTING OFFICE

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02201
REG. NO.1. FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Cora B. Trammell | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan. 7, 1979 | | 2b. HOUR
5 AM | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
July 22 1896 | |
| 6 AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4109 Elby Street | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Wheaton | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Earp | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
(unknown) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
none | | 17. INFORMANT
ADDRESS
John E. Trammell-son (same as 13c) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
410-
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIO SCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
11 HR
10 1/2 | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
NONE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1/6 , 19 79 , to 1/6 , 19 79 , that (1) (we) lost saw the deceased alive on 1/6 , 19 79 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Henry W. Stout, MD | | DEGREE
MD | | 22c. DATE SIGNED
1/8/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Henry W. Stout, MD | | 22e. ADDRESS
10011 Ga. Ave., Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 10-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | 23d. LOCATION
Rockville | | 23e. COUNTY
Montgomery | |
| 23f. ADDRESS
4434 Ga. Ave., S.S. Md. | | 23g. DATE RECD. BY REGISTRAR
Jan 15 1979 | | 23h. REGISTRAR'S SIGNATURE
John E. Trammell | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10550-05

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | 79-02202 | |
|--|--|----------------------|--|--|--|--|--|---|--|---|--|--|--|
| 1- STATE REGISTRAR | | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Harold C. Travers | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1/31 1979 | | | | 2b. HOUR A.M. | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH
MONTH DAY YEAR Mar. 24, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 1/31 1979 | | 2d. HOUR 10:50 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
7610 Maple Avenue, #305 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Military | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Takoma Park | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7610 Maple Avenue, #305 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Unknown | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Laura Travers | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) WWII | | 17. INFORMANT
Marion Travers | | | | ADDRESS
9703 Bristol Ave.
Silver Spring, Md. 20901 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial disease.
4291
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
None | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> | | | | TITLE (SPECIFY)
Deputy | | | | MEDICAL EXAMINER
1919 Seminary Road
Silver Spring, Montgomery, Md. | | | | DATE SIGNED
1/31/79 | |
| EXAMINER'S NAME (TYPE OR PRINT)
John S. Rogers, M.D. | | | | ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | | 23b. DATE
Feb. 1, 79 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Crematory | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood, Prince George, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi F.H. | | | | ADDRESS
11800 New Hampshire Ave.
Silver Spring, Md. 20904 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 6 1979 | | | | 25b. REGISTRAR'S SIGNATURE
<i>Henry A. Brady</i> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

50550-85

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02203
REG. NO. | | | | | |
|---|--|---|--|---|--|--|------------------|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Baby Girl | | | | 2a. DATE OF DEATH | | MONTH
1 | DAY
22 | YEAR
79 | 2b. HOUR
5:48 M |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH 1 DAY 22 YEAR 79 | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR
MONTHS 2 DAYS 15 | IF UNDER 24 HRS.
HOURS 2 MIN. 15 |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Va. | | 13b. COUNTY
Alexandria | | 13c. CITY OR TOWN
Alexandria | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST Paul MIDDLE Tripodo LAST Tripodo | | 15. MOTHER'S MAIDEN NAME
FIRST Betty MIDDLE Anne LAST Priolo | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | | |
| 16b. SOCIAL SECURITY NO.
7650 | | 17. INFORMANT
William Reyer | | ADDRESS
24 Brookebury Dr. Apt. C-1
Reisterstown, Md. 21136 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) prematurity (gestation 25 1/2 weeks)
7650 DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/22/79 , 19____, to 1/24/79 , 19____, that (I) (we) last saw the deceased alive on 1/22/79 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Alton R. Colverman | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/24/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Alton R. Colverman | | | | 22e. ADDRESS
11119 Rockville Pk. Rockville | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1-25-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Columbia Mem. Garden | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Virginia | | | |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Mem. Chap. | | | | Rockville, Md.
1170 Rockville Pk. | | 25a. DATE REC'D. BY REGISTRAR
JAN 26 1979 | | 25b. REGISTRAR'S SIGNATURE
Barney McCreedy | |

BP _____

22-05203

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10-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02204 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Hattie Mae Underkoffler | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-26-79 | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
oct 31, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
76 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY
Shirt co | |
| 13a. STATE
Pa | | | | 13b. COUNTY
Bucks | | 13c. CITY OR TOWN
Quakertown | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harvey Berkenstock | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alavesta Ohl | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
159 07 9951 | | 17. INFORMANT
ADDRESS
Helen Lawrence Hyattsville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Aspiration Pneumonia
5990
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CVA CHX Cerebral - low
DUE TO, OR AS A CONSEQUENCE OF
(c) kidney tract infection - fatal bleed
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-17 , 19 78 , to 1-26 , 19 79 , that (I) (we) lost saw the deceased alive on 1-25 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
R. H. Sandstrom | | | | DEGREE
MD | | 22c. DATE SIGNED
1-26-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. H. Sandstrom | | | | 22e. ADDRESS
7701 Carroll Ave Takoma Park, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan 30, 1979 | | 23c. NAME OF CEMETERY OR CREMATOR
Quakertown Union | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Quakertown Union Bucks Pa | |
| 24. FUNERAL DIRECTOR
NAME
F. Gasch's Sons P A Hyattsville, Md | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 29 1979 | | 25b. REGISTRAR'S SIGNATURE
Jeffrey McCurdy | |

40550-85

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C. 20250

| No. | Name | Origin | Date | Remarks | Remarks |
|-----|-------|--------|------|---------|---------|
| 1 | Apple | China | 1951 | | |
| 2 | Apple | China | 1951 | | |
| 3 | Apple | China | 1951 | | |
| 4 | Apple | China | 1951 | | |
| 5 | Apple | China | 1951 | | |
| 6 | Apple | China | 1951 | | |
| 7 | Apple | China | 1951 | | |
| 8 | Apple | China | 1951 | | |
| 9 | Apple | China | 1951 | | |
| 10 | Apple | China | 1951 | | |

| | | | | | |
|----|-------|-------|------|--|--|
| 11 | Apple | China | 1951 | | |
| 12 | Apple | China | 1951 | | |
| 13 | Apple | China | 1951 | | |
| 14 | Apple | China | 1951 | | |
| 15 | Apple | China | 1951 | | |
| 16 | Apple | China | 1951 | | |
| 17 | Apple | China | 1951 | | |
| 18 | Apple | China | 1951 | | |
| 19 | Apple | China | 1951 | | |
| 20 | Apple | China | 1951 | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #5 Film G528 2/22/79 re

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02205
REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Eleanor R. UNKENHOLZ | | | 2a. DATE OF DEATH MONTH DAY YEAR
01-05-79 | | | 2b. HOUR
7:50 AM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
JULY 2, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
RANDOLPH HILLS NURSING HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U.S. GOVT. | |
| 13a. STATE
MARYLAND | | | | 13b. CITY OR TOWN
MONTGOMERY | | 13c. STREET ADDRESS
8505 SPRINGVALE ROAD | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
PERCY ROBERTS | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
HELEN BAXTER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
081-22-2542 | | 17. INFORMANT SON ADDRESS SILVER SPRING, MD.
WILLARD C. UNKENHOLZ, 11125 EASECREST DRIVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the Colon with metastases
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Arteriosclerotic heart disease | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 19 78 , to January 19 79 , that (I) (we) last saw the deceased alive on Dec 26 19 78 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Israel Spector MD | | | | DEGREE | | 22c. DATE SIGNED
Jan 5 1979 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Israel Spector MD | | | | 22e. ADDRESS
911 Silver Spring Avenue Silver Spring Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
1/9/79 | | 23c. NAME OF CEMETERY OR CREMATORY
ORCHARD ST. CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
LIVINGSTON MANOR, SULLIVAN, NY | |
| 24. FUNERAL DIRECTOR NAME
FRANCIS J. COLLINS | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 8 1979 | | 25b. REGISTRAR'S SIGNATURE
History McLeod | |
| 26. ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. | | | | | | | |

79-05502

UNKNOWN

UNKNOWN

8.

75

JULY 2, 1903

WHITE

FEMALE

MONTGOMERY

XX

U.S.A.

NEW YORK

U.S. GOVT.

RANDOLPH HILLS RISING HUNT

SILVER SPRING

6505 SPRINGVALE ROAD

X

SILVER SPRING

MONTGOMERY

MARYLAND

DAUGHTER

HELEN

ROBERTS

PERCY

SON

SILVER SPRING, MD.

WILLIAM C. UNKNOWN

801-22-2242

10

11125 EASTGATE DRIVE

800 WINDY BLVD., SILVER SPRING, MD.

FRANCIS J. COLLINS

1/8/79

TRIAL

ORCHARD ST. CEMETERY

LIVINGSTON MANOR, SULLY, NY

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-02206 | |
|---|------------------------------------|--|--|---|--|--|--|--|--|-------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Louis Steven Vassos | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED Jan 31, 1979 | | 2b. HOUR 4:30
A.M. <input checked="" type="checkbox"/> P.M. <input type="checkbox"/> | | | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH
MONTH Feb DAY 25 YEAR 1916 | 6. AGE (IN YEARS)
LAST BIRTHDAY 62 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD Jan. 31, 1979 | | 2d. HOUR 4:30
A.M. <input checked="" type="checkbox"/> P.M. <input type="checkbox"/> | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH Tak. Park | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash Advent Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Caterers-Restaurant | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS 2018 Poughkeepsie Rd | | | |
| 13a. STATE Md | 13b. COUNTY Prince George's | 13c. CITY OR TOWN Hyattsville | | | | | | | | | |
| 14. FATHER'S NAME
FIRST Stephen MIDDLE J. LAST Vassos | | | 15. MOTHER'S MAIDEN NAME
FIRST Effie MIDDLE Zaharoolis LAST | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) Yes
(IF YES, GIVE WAR OR DATES) WWII | | | 16b. SOCIAL SECURITY NO. 025 33 3349 | | 17. INFORMANT Same as above
Dorothy M. Vassos (Wife) | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Urinary infection and Bronchitis
DUE TO, OR AS A CONSEQUENCE OF
(c) Pneumonia
Fractured skull and Subdural Hematoma | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Sec. to 2821 | | | | | | | | | | | |
| 19a. DATE OF OPERATION 1-28-79 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Subdural Hematoma | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 438 PM 1227 1979 | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR 438 PM 1227 1979 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Tripped on fall | | | | | |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Restaurant | | | 21f. LOCATION
STREET L. St. NW. CITY OR TOWN Wash. COUNTY DC STATE DC | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John G. Rogers | | | TITLE (SPECIFY) M.D. | | | MEDICAL EXAMINER 1919 Seminary Rd. S.S.Md. | | | DATE SIGNED Feb. 4, 1979 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/5/79 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Brentwood PG Md. | | | 23d. LOCATION
CITY OR TOWN PG COUNTY Md. STATE Md. | | | |
| 24. FUNERAL DIRECTOR
NAME Hines/Rinaldi F.H. ADDRESS 11800 N.H.Ave. Silver Spring, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 6 1979 | | 25b. REGISTRAR'S SIGNATURE Dorothy M. Vassos | | | |

19-02206

WESTERN EXAMINING CORPORATION

602

USA

Mass.

CONTINENTAL-BREITENBURG

Grapher J. Vasson
Billie Vasson
Same as above
025 33 3349 Dorothy M. Vasson (Wife)
Yes

1919 Seminary Rd. S.S.M.

John G. Rogers

Burial 1/5/79 Fort Lincoln Cemetery Greenwood PG Md.

Witness/Minister W.E. 11800 N.E. Ave. Silver Spring, Md.

| 1- STATE REGISTRAR | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | 79-02207 | |
|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE KNOWN OF DEATH | |
| Frank Villiotti | | | | 2b. DATE KNOWN OF DEATH ESTI- MATED | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| M | | W | | XXXXXX 76 82 | |
| 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | |
| 82 | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | |
| ITALY | | U.S.A. | | NEVER MARRIED | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Silver Spring | | Whitman Hvr. Home | | TRUCK DRIVER | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MD | | Mont | | Silver Spring | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | |
| VILLIOTTI | | VILLIOTTI | | YES WW I | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 182-28-4416 | | FRED F. VILLIOTTI | | SAME AS 13 SON | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) 4409 Broncho pneumonia | | | | 36 hrs | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) Generalized Arteriosclerosis | | | | 1 yr | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| Fracture Rt. Hip. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| 12-14-78 | | Fracture Rt. Hip | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 12 14 78 | | Fall on street | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | Street | | Silver Spring | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | |
| death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| [Signature] | | M.D. Day | | Jan 26 1979 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| JOHN S. ROGERS | | 1919 SEMINARY ROAD, SILVER SPRING, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 1/29/79 | | GATE OF HEAVEN | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | JAN 29 1979 | | [Signature] | |
| FRANCIS J. COLLINS | | 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | |

10-05501

TRUCK DRIVER

WILLIOTT

YES UNIT 181-28-4416 WEDD F. WILLIOTT SAME AS IS 20M

1919 2E YWARY ROAD SILVER SPRING MD

JOHN S. H. PETS

SILVER SPRING MONT

DATE OF DEATH

FRANCIS J. COLLINS

500 UNIV. BLVD., W. SILVER SPRING, MD. 20901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02208
REG. NO.

| | | | | | | | | | |
|---|--|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) GORDON H. WALCK | | | 2a. DATE OF DEATH
MONTH 1 / DAY 1 / YEAR 79 | | | 2b. HOUR
12:00 AM | | | |
| 3. SEX
male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH 01 / DAY 16 / YEAR 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | | 7. UNDER 1 YEAR
MONTHS / DAYS / HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery, MD. | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
WRAFI | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spr. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST Norman MIDDLE H. LAST Walck | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE J. LAST Nattress | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) yes | | | | | |
| 16b. SOCIAL SECURITY NO.
WW 11 | | 17. INFORMANT
ADDRESS
Mildred R. Walck-wife=(same as 13e) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiogenic Shock
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (c) Anteromedullary Spinal Disease
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.
410-
Diabetes Mellitus | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr
1 hr
5 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Jun 19 77 to 1 Jan 79 , that (1) (we) lost saw the deceased alive on Dec 19 78 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death. | | | | | | | | 22c. DATE SIGNED
1/1/79 | |
| 22b. SIGNATURE
Alan I. Kermaier, MD | | | | | | | | 22e. ADDRESS
9801 Georgia Ave. S.S. Md 20902 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALAN I. KERMAIER, MD | | 22f. ADDRESS
9801 Georgia Ave. S.S. Md 20902 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1-3-1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Laurel Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hazleton Pa. | | | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc
8434 Ga. Ave., S.S. Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1979 | | 25b. REGISTRAR'S SIGNATURE
Joseph McCreedy | | | |

BP

13-05508



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02209
REG. NO.

| | | | | | | | | | | | |
|---|--|---|---|---|--|--|-------------------|--|-----------|------------|--------------------------------|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
EDYTHE | MIDDLE
B | LAST
WALLACE | 2a. DATE OF DEATH | MONTH
01 | DAY
07 | YEAR
79 | 2b. HOUR
8:25P _M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 11 1905 | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
OLNEY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MONTGOMERY GENERAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Mont. | 13c. CITY OR TOWN
Sandy Spring | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
17310 Quaker Lane | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Amos Ward Beall | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nora Willison | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
578-32-9265 | | 17. INFORMANT
ADDRESS
Mason Wallace (Husband) Same as above | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
5789
DUE TO, OR AS A CONSEQUENCE OF
(b) ANEMIA: HYPOXEMIA
DUE TO, OR AS A CONSEQUENCE OF
(c) GASTROINTESTINAL BLDG
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 DAYS
1 WK -
1 WK - | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
HYPERTENSIVE CVD - | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from July 27, 1979, to 1/7, 1979, that (I) (we) last saw the deceased alive on 1/3, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) I did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
D. R. Lewis | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/8/79 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
D. R. LEWIS MD | | 22e. ADDRESS
OLNEY, MARYLAND | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/10/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Geo. Washington | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Adelphi PG Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi | | F.H. 11800 | | N.H. Ave. Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 11 1979 | | 25b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
CARL | | MIDDLE
L. | | LAST
WARD | | 2b. DATE KNOWN OF DEATH | | 2c. DATE OF ESTI-MATED DEATH | |
| 3. SEX
Male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct 1 1960 | | 6. AGE (IN YEARS LAST BIRTHDAY)
MONTHS DAYS HOURS MIN
YRS. | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | |
| 7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery | | 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery Gen. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
ret. | | 12b. KIND OF BUSINESS OR INDUSTRY
machinist | |
| 13a. STATE
Md | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
367 West Side Dr. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Willard Ward | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Laura Mae unknown | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
WW II 409-09 0931 | | 17. INFORMANT
ADDRESS
Frances I. Ward same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u>
4399 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> }
lying cause last. } (b) <u>Chronic Cardiac Respiratory Dis</u>
DUE TO, OR AS A CONSEQUENCE OF }
(c) <u>Yrs.</u> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>None</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>None</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
<u>John Rogers</u> | | TITLE (SPECIFY)
M.D. <u>Doc</u> | | MEDICAL EXAMINER | | | | DATE SIGNED
<u>Jan 18, 1979</u> | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
John Rogers | | ADDRESS
Silver Spring, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/18/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Cheltenham Veterans Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cheltenham, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Lyson Wheeler Funeral Home, Inc. | | ADDRESS
1331 Rockville Pike, Rockville, Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 19 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Anthony McCready</u> | | | | | |

10-05510

LEAD

CELE

Montgomery Gen Hospital

City

20% COLLOID



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02211
REG. NO.

| | | | | | | | |
|---|--|---|---|--|----------------------------|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GEORGE Sprigg WARD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan-30/79 | | 2b. HOUR
4 45 AM | | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
6-23-92 | | 6 AGE (IN YEARS LAST BIRTHDAY)
86
YRS MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Mont. MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN- | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY
Self-employed | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
25 Cedar Ave. | | | | | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Charles Ward | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hattie Duvall | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-01-6789 | | 17 INFORMANT
ADDRESS
Mrs. Julia Walker 108 Cedar Ave. Gaithersburg, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro Vascular Accident
436-
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week
years | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1/29/79 to 1/30/79 , that (I) (we) lost saw the deceased alive on 1/29/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Thos G. Ward DEGREE 3 & | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/30/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thos G. WARD | | | | 22e. ADDRESS
6116 Robinson Rd Bethesda Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Feb. 1, '79 | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Oak Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Gaithersburg Montg. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Gartner-Sandison F. H. | | | | ADDRESS
316 Diamond Avenue Gaithersburg, Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1979 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Barney McCurdy | | | |

BP

13-05511

COTTON FIBER

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02212

REG. NO.

| | | | | | | | | | | | | |
|---|--|--|---|---|--|--|-------------------|-------------|-----------|------------|---------------------|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Ida | MIDDLE
Norine | LAST
Ward | 2a. DATE OF DEATH | MONTH
01 | DAY
30 | YEAR
79 | 2b. HOUR
11:55PM | |
| 3 SEX
Female | 4 RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 26, 1885 | 6 AGE (IN YEARS LAST BIRTHDAY)
93 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montg. Gen. Hosp., Olney, Md. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Gaithersburg | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
23646 Woodfield Rd. | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Luther N. King | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Florence Burdette | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-36-9127 | | 17. INFORMANT
ADDRESS
Robert M. Ward, 24101 Woodfield Rd.
Gaithersburg, Md. | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u>
4409 DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Sepsis secondary to gangrene of leg 10 days</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(c) <u>Unhealed arteriolectomy</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
1/9/79 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Surgical left leg. | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/8/79</u> , 19 <u>79</u> , to <u>1/30</u> , 19 <u>79</u> , that (I) (we) lost
saw the deceased alive on <u>1/30</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>D. Corn</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/31/78 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
David Corn | | 22e. ADDRESS
18111 Prince Philip Dr. Olney, Md. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Feb. 2, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Upper Seneca Baptist | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cedar Grove, Montg., Md. | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Olin L. Molesworth, Damascus, Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Anthony McCreedy</u> | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 2 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02213
REG. NO. | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Ronald M Warren | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1-2-1979 | | | | 2b. HOUR
4:45 A.M. | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
OCT 14, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
ASST. TO PRES. OF | | 12b. KIND OF BUSINESS OR INDUSTRY
SOCIETY AMER. CHEMICAL | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
CHARLES WARREN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
GLADYS MORRIS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
342-20-6536 | | 17. INFORMANT ADDRESS
EVELYN C. WARREN SAME AS 13 WIFE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular accident
436-
DUE TO, OR AS A CONSEQUENCE OF
(b) Advanced atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Essential Hypertension | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
4 years
3 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
99 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 77 to 1/2 19 79 , that (I) (we) lost
saw the deceased alive on 1/1 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
HUGH IREY | | | | DEGREE
M.D.
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/2/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HUGH IREY | | | | 22e. ADDRESS
11161 NEW HAMPSHIRE AVE., SILVER SPRING, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
1/5/79 | | 23c. NAME OF CEMETERY OR CREMATORY
PARKLAWN CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
ROCKVILLE MON T MD. | | | |
| 24. FUNERAL DIRECTOR NAME
FRANCIS J. COLLINS | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 8 1979 | | 25b. REGISTRAR'S SIGNATURE
Henry McCreedy | | | |
| 25c. ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | |

VEER MEER

FRANCIS J. COLLINS

10000 . 01.01.2012 17:11:12 . 4 . 01.01.2012 17:11:12

WHITEFIELD

NAME: Anna H. Waters

DATE OF DEATH: January 7, 1979

PLACE OF DEATH: Montgomery County

SEE: #79-04842
February, 1979
Montgomery County

WHITEFIELD

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02214
REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Edna E. Watts | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan 1 1979 | | | 2b. HOUR
7:30 P M | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
Mar 2 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86
YRS. MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Missouri | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Kensington | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Kensington Gardens Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | |
| | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
US Govt. | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spr. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Watts | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ada Wickham | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
none | | 17. INFORMANT
ADDRESS
9602 Margaret L. Acton-niece-Bristol Ave | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>1749</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) <u>Carcinoma breast primary</u> | | APPROXIMATE INTERVAL BETWEEN ONSET OF DISEASE AND DEATH
<u>weeks</u>
<u>months</u> |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 26</u> , 19 <u>78</u> , to <u>Jan 1</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Dec 26</u> , 19 <u>78</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>A.W. Smith M.D.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>1/1/79</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>A.W. SMITH</u> | | | | 22e. ADDRESS
<u>13018 GEORGIA AVE
WILKESBORO, MD. 20906</u> | | | |

| | | | | | | | |
|---|--|---------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Jan. 4, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Montgomery Md. | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc.
8434 Ga. Ave., S.S. Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Anthony McCreedy</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02215 | |
|---|--|--|--|---|--|---|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
ELNO JAMES WEBER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1-21-79 | | | 2b. HOUR
2:25 AM | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
May 24, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Letter Carrier | | 12b. KIND OF BUSINESS OR INDUSTRY
P.O. | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5804 Lone Oak Dr. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
(Unknown) Weber | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Ada Weber | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216-44-9231 | | 17. INFORMANT
Julia A. Weber | | ADDRESS
Same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal failure, Cause undetermined
DUE TO OR AS A CONSEQUENCE OF (b) Chronic Bronchitis & Emphysema
DUE TO OR AS A CONSEQUENCE OF (c) Pneumonia
Approximate interval between onset and death: 10 days
586-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
Diabetes Mellitus; Diffuse Intravascular Coagulopathy; Hypertension
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) 586- | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from September 19, 72 , to January 21, 1979 , that (I) (we) last saw the deceased alive on January 20, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
G. Stuart Scott MD | | | | | DEGREE
MD | | 22c. DATE SIGNED
Jan 21, 1979 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G. Stuart Scott | | | | | 22e. ADDRESS
Bethesda, Md.
10401 Old Georgetown Rd. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 24, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME
Robert A. Pumphrey | | 24b. ADDRESS
Homes, P.A. Bethesda, Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 24 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02216
REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SYLVIA LEVIN WEINSTEIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1/21/79 | | | 2b. HOUR
6⁰⁵ pm | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 26, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales | | 12b. KIND OF BUSINESS OR INDUSTRY
Clothing | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Pennsylvania | | | | | 13b. COUNTY
Phila., Co. | | 13c. CITY OR TOWN
Philadelphia | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie Borish | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
159-26-4119 | | 17. INFORMANT
Michael Weinstein
ADDRESS
2802 Spiral Lane
Bowie, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis
3360 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypoxemia
} DUE TO, OR AS A CONSEQUENCE OF (c) SYRINGOMYELIA | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 DAYS
4 DAYS
10 YRS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/14/79 , 19 1975 , to 1/21/79 , 19 1979 , that (I) (we) lost saw the deceased alive on 1/21/79 , 19 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death, so state.) | | | | | | | | | | |
| 22b. SIGNATURE
Henry C. Scruggs MD | | | | | DEGREE
MD | | 22c. DATE SIGNED
1/22/79 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Henry C. Scruggs MD | | | | | 22e. ADDRESS
5413 Cedar Lane Bethesda Md - | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
1/23/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Alliance Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Norma, New Jersey | | | |
| 24. FUNERAL DIRECTOR
NAME
Donald M. Stein Hebrew Memorial F.H. | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 23 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |
| 232 Carroll St., N.W., Washington, D. C. | | | | | | | | | | |

BP

1a-05518

OFFICE OF THE DIRECTOR
BUREAU OF THE ARMY
WASHINGTON, D.C.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-02217
REG. NO.

| | | | | | | | | |
|---|--|---|---------------------------------|---|--|-----------------------------------|--|--------------------------------|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Freeman | MIDDLE | LAST
WELCH, JR. | 2a. DATE OF DEATH
MONTH DAY YEAR
January 23 1979 | 2b. HOUR
1210A M |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
July 5 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Tennessee | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Naval Medical Center | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U. S. Navy | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Virginia | | 13b. COUNTY | 13c. CITY OR TOWN
Alexandria | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3315 Southgate Drive Apt. 104 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Freeman Welch Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha Tompkins | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes 1944-67 | | | | |
| 16b. SOCIAL SECURITY NO.
268 20 9998 | | 17. INFORMANT
ADDRESS
Mrs. Irene M. Welch See item 13 | | | | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Increased intracranial pressure</u>
<u>1729</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Malignant melanoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

| | | | |
|--|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 3</u> , 19 <u>78</u> , to <u>Jan. 23</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Jan. 23</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>J. Stephen Bohan</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
Jan. 23, 1979 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Stephen, Bohan, M.D. | | 22e. ADDRESS
National Naval Medical Center, Bethesda, Md. | |

| | | | |
|--|----------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
1/26/79 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Arlington Va. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<u>St. Ignace</u>
Cunningham Funeral Home Alexandria, Va. | | 25a. DATE REC'D. BY REGISTRAR
JAN 29 1979 | 25b. REGISTRAR'S SIGNATURE |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

19-02217

| | | | |
|-----------|-------------------------------|---|----------|
| Freeman | WELCH, JR. | January 22 1979 | 1210A |
| Male | Concession | July 3 1938 | 61 |
| Tennessee | USA | Montgomery | |
| Cathedral | National Naval Medical Center | U. S. Navy | |
| Virginia | Alexandria | 3512 Southgate Drive Apt. 104 | |
| Freeman | Welch Sr. | Berlin | Trunking |
| Yes | 1944-67 | 268 20 9298 Mrs. Irene M. Welch See item 12 | |

Increased intracranial pressure
Malignant neoplasm

| | | | |
|--------------------------|--|-----------------|-----------|
| Burial | Cunningham Funeral Home | Alexandria, Va. | |
| | Atlington | Atlington | Atlington |
| J. Stephen, Foster, M.D. | National Naval Medical Center, Bethesda, Md. | Jan. 23 1979 | X |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02218 | | | |
|--|--|--|---|--|------------------------------------|---|---|--|--|-----------------|----------|-----------------|--|
| 1. FOR
STATE
REGISTRAR | | | REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | 2b. HOUR | | |
| Meredith J. Welp | | | | | | 1-12-79 | | | 4:10 | | A M | | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | | Cauc. | | 7 21 29 | | | 49 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Massachusetts | | | U.S.A. | | | | | | Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Silver Spring | | | Holy Cross Hospital | | | Homemaker | | | Home | | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | |
| Md. | | | Montg. | | Rockville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5011 McCall Street | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| Raymond | | | Dillon | | | Mary Ellen Flanagan | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | | 21-22-0290 | | | Theodore L. Welp (Same as 13e) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gastrointestinal bleeding</u>
1749
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Adenocarcinoma of Breast</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>few days</u>
<u>5 yrs</u> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/11</u> 19 <u>79</u> , to <u>1/12</u> 19 <u>79</u> , that (I) (was) last saw the deceased alive on <u>1/11</u> 19 <u>79</u> , and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | |
| <u>J. Lennard Gold</u> | | | 4.D | | | | | | 11/12/79 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | | |
| J. Lennard Gold | | | 8630 Fenton Street, Silver Spring, Md. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| BURIAL | | | 1-15-79 | | Gate of Heaven Cem. | | | Silver Spring Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Md. | | | JAN 10 1979 | | | <u>John J. McCreedy</u> | | | | | | | |

81550-05



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-02219

| | | | | | | | | | | |
|--|--|---|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Raymond Wermter | | | 2a. DATE OF DEATH
MONTH 01 DAY 9 YEAR 79 | | | 2b. HOUR
2P M | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH FEB DAY 1 YEAR 1925 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery county MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DEPARTMENT OF THE NAVY | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10828 MARGATE ROAD | |
| 14. FATHER'S NAME
FIRST MAX MIDDLE WERMTER LAST WERMTER | | | 15. MOTHER'S MAIDEN NAME
FIRST AMELIA MIDDLE KRETSCHMER LAST KRETSCHMER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT
ADELAIDE A. WERMTER | | | ADDRESS
SAME AS 13 WIFE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic disease
1539
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma colon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) 7 mos. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-27, 1978 , to 1-9, 1979 , that (I) (we) last saw the deceased alive on 1-9, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Edward J. Richards M.D. | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-9-79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDWARD J. RICHARDS | | | | | | 22e. ADDRESS
10301 GEORGIA AVENUE, SILVER SPRING, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
1/12/79 | | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ARLINGTON VIRGINIA | | | |
| 24. FUNERAL DIRECTOR
NAME FRANCIS J. COLLINS ADDRESS 500 500 UNIV. BLVD., W., SILVER SPRING, MD., 20901 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

12-05512

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #188 Film 6528 2/28/79 rc
 FOR
 1- STATE
 REGISTRAR
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

79-02220
 REG. NO.

| | | | | | | | | | | |
|---|--|--|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ADA XXXX VERA XX WESTON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JAN. 30 1979 | | | 2b. HOUR
10 A M | | | | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
MONTH DAY YEAR
NOV 26, 1889 | | 6 AGE (IN YEARS LAST BIRTHDAY)
89 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
OHIO | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10 CITY OR TOWN OF DEATH
WHEATON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
RANDOLPH HILLS NURSING HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2903 NEWTON STREET | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
BRINTON BELL HOOPES | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ABIGAIL E. MOORE | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
579-14-3828 | | 17 INFORMANT
DAUGHTER | | ADDRESS
WOODBINE, MD.
FRANCES W. AXTELL, 2064 FLORENCE ROAD | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardio respiratory collapse</u>
4/40
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>multiple embolic phenomenon</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>assault with arterial fibrillation</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1978</u> to <u>1/30</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1/27</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Joseph M. Solinas</u> | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
1/30/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOSEPH M. SOLINAS MD | | | 22e. ADDRESS
9801 GEORGIA AVE. S.S. MD 20902 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
2/2/79 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SUITLAND PRI GEO MD. | | |
| 24 FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | 24b. ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Robert McCurdy</u> | | |

18-05550



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02221 | |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) Lawrence Allen Wichmann | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 11, 1979 | | 2b. HOUR
5:27 | | A
M | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
February 28, 1960 | | 6. AGE (IN YEARS LAST BIRTHDAY)
18 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Kentucky | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
The Clinical Center, NIH Bethesda Md | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Student | | 12b. KIND OF BUSINESS OR INDUSTRY
School | |
| 13a. STATE
Kentucky | | 13b. COUNTY
Jefferson | | 13c. CITY OR TOWN
Louisville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1010 Hathaway Avenue | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Wichmann | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary F. | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
407-88-1887 | | 17. INFORMANT Louisville, Kentucky 40215
Mrs. Mary F. Wichmann, 1010 Hathaway Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis with systemic hemorrhage
2002
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF
(b) Burkitt's lymphoma
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 weeks
6 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from November 28, 1978 , to January 11, 1979 , that (X) (we) lost saw the deceased alive on January 11, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check X.) | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Raul Alvarez</i>
DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Raul Alvarez | | | | | | 22e. ADDRESS
of Health, Bethesda, Md 20014
The Clinical Center, National Institutes | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/13/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Louisville Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Louisville, Jefferson Ky. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
W.W. Chambers Co., Silver Sprg., Md. 20910 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>Robert M. Brady</i> | | | |

BP

19-05551

INSTRUCTIONS

School

Student

Entry

Wisconsin

Wisconsin

U.S.A.

19-05551

19-05551

19-05551

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02222 |
|---|--|---|--|---|---|--|---|---|--|----------|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. |
| 1. DECEASED NAME
(TYPE OR PRINT) JOHN Stephen WILDER Jr. | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-9-79 | | | 2b. HOUR
12 25 PM | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 4, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Georgia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Hotel | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
10401 Grosvenor Place | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Stephen Wilder Sr. | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lydia Penton | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | 17. INFORMANT
Lola A. Wilder (same as 13e) | | ADDRESS | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEPATIC FAILURE
5712
DUE TO, OR AS A CONSEQUENCE OF
(b) CIRRHOSIS, LAENNEC'S
DUE TO, OR AS A CONSEQUENCE OF
(c) LLL PNEUMONIA | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
9 DAYS
2 1/2 YRS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
LLL PNEUMONIA | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
none | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from June 19 78 , to Jan 8 19 79 , that (1) (was) lost saw the deceased alive on Jan 8 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (was) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Allen J O'Neill M.D. DEGREE M | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Jan 10, 1979 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Allen J O'Neill M.D. | | | | | | 22e. ADDRESS
8601 Old Georgetown Rd Bethesda Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1979 January 12 | | 23c. NAME OF CEMETERY OR CREMATORY
Bonaventure Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Savannah Georgia | | | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home, Rockville, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 17 1979 | | 25b. REGISTRAR'S SIGNATURE
Anthony McCready | | |

BP

19-02222

Section 19

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02223

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Charles T. Wilhelm</u> | | | 2a. DATE OF DEATH
MONTH DAY YEAR <u>11/8/79</u> 25-86 | | | 2b. HOUR
<u>6:39 PM</u> | |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR <u>10 26 06</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>72</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>MARYLAND</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>Bethesda</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Suburban Hospital</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>DRIVER</u> | |
| 12b. KIND OF BUSINESS OR INDUSTRY
<u>DISTRIBUTOR</u> | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
<u>MARYLAND</u> | | 13b. COUNTY
<u>ALLEGANY</u> | | 13c. CITY OR TOWN
<u>FROSTBURG</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
<u>61 BROADWAY</u> | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST <u>THOMAS WILHELM</u> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST <u>EFFIE GARLITZ</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) <u>217-09-7020</u> | | 17. INFORMANT
ADDRESS <u>MRS. FLORENCE WILHELM, FROSTBURG MD.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) <u>Anticoagulant hemorrhage</u> 24 hrs. | | | | | | | |
| (c) <u>Cerebral arteriosclerosis</u> years | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>June</u> , 19 <u>73</u> , to <u>1-8</u> , 19 <u>79</u> , that (I) (we) lost
saw the deceased alive on <u>1-8</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>John F. Tauber</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>1-8-79</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>John F. Tauber</u> | | 22e. ADDRESS
<u>8218 Wisconsin Ave Bethesda Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <u>BURIAL</u> | | 23b. DATE
<u>JAN. 12, 1979</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>ST. PATRICKS CEMETERY</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>CUMBERLAND MD.</u> | |
| 24. FUNERAL DIRECTOR
NAME <u>DURST FUNERAL HOME, FROSTBURG, MD.</u> | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
<u>JAN 16 1979</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Henry McCreedy</u> | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

10-05553



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-02224
REC. NO.

| | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|------------------|--|---|--|--|--|--|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH
KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>
MONTH DAY YEAR
1 1 1979 | | | | | | | | | | 2b. HOUR
7:10p | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Carrie Virginia Wilkerson | | | | | | | | | | | | 2c. DATE
PRONOUNCED
DEAD
1 1 79 7:10p | | | | | | | |
| 3. SEX
Female. | | 4. RACE
White. | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 12, 1911 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
67RS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | 2d. DATE
PRONOUNCED
DEAD
1 1 79 7:10p | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park. | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Home Maker. | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland. | | | | | | | | | | | | 13b. COUNTY
Montgomery. | | 13c. CITY OR TOWN
Silver Spring. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
829 Bonifant St. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Herbert Johnson. | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Carrie Edwards. | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No. | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT
10310 Greenacres Dr. S. S.
Steve Wendell Wilkerson. (Son) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u>
4149
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Richard L. Wheelton | | | | | | TITLE (SPECIFY)
Deputy | | | | | | MEDICAL EXAMINER
DATE SIGNED
Jan 1, 1979 | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
RICHARD L. WHEELTON | | | | | | ADDRESS
7100 Baltimore Ave College Park | | | | | | | | | | | | | |
| 23a. BURIAL INFORMATION, REMOVAL (SEE ITEM 1) | | | | | | 23b. DATE
Jan. 5, 1979 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Union Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY
Parkville Montg. Md. | | | | | |
| 24. FUNERAL DIRECTOR
J. Walter Walker | | | | | | ADDRESS
254 Carroll St NW
Washington DC 20012 | | | | | | 25a. DATE REC'D. BY REGISTRAR
Jan 8 1979 | | 25b. REGISTRAR'S SIGNATURE
Anthony J. Crady | | | | | |

79-02224

x

Carla Virginia Wilkerson

Washington Ventral Hospital

Washington Ventral Hospital

Washington Ventral Hospital

Washington Ventral Hospital

Washington Ventral Hospital

Washington Ventral Hospital

Washington Ventral Hospital

Washington Ventral Hospital

Washington Ventral Hospital

Washington Ventral Hospital

Washington Ventral Hospital

Washington Ventral Hospital

Washington Ventral Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02225
REG. NO. | |
|--|--|--|--|---|---|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Clarence Theodore Wilks | | | 1979 | | 1A M |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR
12/18/1883 | 6. AGE (IN YEARS LAST BIRTHDAY)
95 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Connecticut | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Carriage Hill-Bethesda 5215 Cedar Lane | | 12a. USUAL OCCUPATION
Executive Manager | 12b. KIND OF BUSINESS OR INDUSTRY
General Motors | |
| 13a. STATE
Connecticut | | | 13b. COUNTY
New Haven | 13c. CITY OR TOWN
Wallingford | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Walter L. Wilks | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Emma Edell | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
574-03-6198A | 17. INFORMANT ADDRESS
W. Samuel Wilks, 5627 Bent Branch Rd. Washington, D.C. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral infarction</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION
None | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 17</u> , 19 <u>78</u> , to <u>present</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>1/8</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
MD | | 22c. DATE SIGNED
1/9/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
[Signature] | | 22e. ADDRESS
8805 Conn. Ave. Chevy Chase Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
1/13/79 | 23c. NAME OF CEMETERY OR CREMATORY
In Memoriam Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Wallingford, Connecticut | |
| 24. FUNERAL DIRECTOR NAME
Robert A. Pumphrey | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02226
REG. NO. | |
|---|--|--|-----------------------|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Ernest W Wilson | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1-3-79 | | | 2b. HOUR
5:58 P.M. | | |
| 3. SEX
M | | 4. RACE
C | | 5. DATE OF BIRTH MONTH DAY YEAR
5 13 85 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY
Hardware | | |
| 13a. STATE
Maryland | | | | | | 13b. CITY OR TOWN
Montgomery Silver Spring | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
9825 Dallas Avenue, | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
(unknown) | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
(unknown) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
none | | 17. INFORMANT ADDRESS
Emma B. Wilson-wife-(same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory - Cardiac Arrest</u>
4160
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Chronic Pulmonary Hypertension</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
mins
years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Recurrent Pulmonary embolism</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 18</u> , 19 <u>78</u> , to <u>Jan 3</u> , 19 <u>79</u> , that (I) <u>have</u> lost
saw the deceased alive on <u>Dec 18</u> , 19 <u>78</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated
above. (I) <u>viewed</u> (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Harold W. Draper M.D. | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
Jan 4, 1979 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAROLD W. DRAPER M.D. | | | | | | 22e. ADDRESS
9801 GEORGIA AVE, Silver Spring | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
1-6-1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Jefferson Reformed | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Frederick Fred. Md. | | | |
| 24. FUNERAL DIRECTOR
Name
Warner E. Pumphrey, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 10 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |
| 8434 Ga. Ave., S.S. Md. | | | | | | | | | | | |

18-05558

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02227
REG. NO. | |
|---|--|---|----------------------------------|---|--|---|-------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| | | | Lois F. Wilson | | | | January 8, 1979 | | | 11:05A | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | White | | Oct. 4 1908 | | 70 | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| N.C. | | U.S.A. | | | | Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Takoma Park | | Wash. Adventist Hospital | | | | Housewife | | Own Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | Pr. Geo. | | Hyattsville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4204 Tuckerman St. | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| James W. Fowler | | | | Julia Baucom | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | | | 578-28-0417A | | Arthur P. Stewart (son) Boca Raton, Fla. | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u>
2050
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/14 78 to 1/8 79, that (I) (we) lost saw the deceased alive on 1/8 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE
DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22c. DATE SIGNED
1-8-79 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| Lewis H. Dennis, M.D. | | | | 831 Univ Blvd E. Sil Spg, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 1/11/79 | | Grace Meth Ch. Cem | | Monroe Union N. C. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| F. Gasch's Sons F.H. P.A. Hyatts. Md. | | | | JAN 11 1979 | | | | | | | |

79-02227

| | | | |
|--------|---------------------|---|--------------|
| 11:02A | January 8, 1979 | Wilson | Male |
| | 70 | Oct. 4 1908 | Female |
| | Montgomery | X | U.S.A. |
| | Own home | Housewife | Unknown Fair |
| | 4204 Tricketman St. | X | Unknown Fair |
| | Wilson | Julia | James |
| | | Rowler | No |
| | | 1-2-41 A. Arthur E. Stewart (son) 1000 N. 1st St. | |

1-8-79

221 University E. St. St. Louis, Mo.

Lewis H. Smith, M.D.

1117 1/2 N. 1st St. St. Louis, Mo.

1. 1000 N. 1st St. St. Louis, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02228 | | |
|--|--|---|--|---|--|--|--|--|--|---|----------|--|
| 1. FOR
STATE
REGISTRAR | | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | 2b. HOUR | |
| Bud Douglas Wines | | | | | | 1-14-79 | | | 3:05 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Male | | White | | May 7 1902 | | 76 | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Virginia | | USA | | | | Montgomery MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Takoma Park | | Washington Adventist Hospital | | | | | | Plumber | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. STATE | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | |
| D.C. | | | Washington | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | | | |
| | | | | | | | | | 6327 Foster Street, S.E. | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | | | | | | | | |
| John Wines | | | Elizabeth Fletcher | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | | |
| No | | | 579-18-8807 | | | Rt. 2, Box 241, Bealeton, Va.
Ethel Jennings, Daughter | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>4 months</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-4</u> , 19 <u>78</u> , to <u>1-14</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1-13</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED | | | | | | |
| Kai-Yin Yeung MD. | | | | | | 1-15-79 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | |
| Kai-Yin Yeung MD. | | | 6525 Belmont Rd #460 Hyattsville, MD 20782 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | | 1-17-79 | | | Ft. Lincoln Cem. | | | Brentwood, P.G., Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | | 24b. ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robt E Wilhelm | | | 4308 Suitland Rd., Suitland, Md. | | | JAN 19 1979 | | | [Signature] | | | |

BP _____

18-05558

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicobagaine must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-02229

| | | | | | | | | | | |
|--|--|--|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARTHA E WINKLER | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 / 23 / 79 | | | 2b. HOUR 11:05 AM | | | | |
| 3. SEX Female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 21 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N, Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel-Pre Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY own home | | |
| 13a. STATE Maryland | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Sil. Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 725 Gist Avenue, | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Cleveland Teague | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Sherrill | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. 578-05-1937 | | 17. INFORMANT ADDRESS 808 Richmond Margaret Kane-daughter-Ave., S.S. Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 16 Jan 19 79 to 23 Jan 19 79 , that (I) (we) last saw the deceased alive on 16 Jan 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE William D. Aud | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/23/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Aud, MD | | | 22e. ADDRESS 9006 Colesville Road, S.S. Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Jan. 25, 79 | | 23c. NAME OF CEMETERY OR CREMATORY George Washington | | 23d. LOCATION (CITY OR TOWN) COUNTY Adelphi Pr. Georges Md. | | | |
| 24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. | | | 25a. DATE REC'D. BY REGISTRAR JAN 29 1979 | | | 25b. REGISTRAR'S SIGNATURE Robert McCreedy | | | | |
| 24a. ADDRESS 8434 Ga. Ave., S.S. Md. | | | 25c. SIGNATURE Clark E. Wilson | | | | | | | |

MEDICAL CERTIFICATION

29

1

10-05550

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-02230

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) BERTHA G. WINNICK | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/31/79 | | | 2b. HOUR 12⁰⁰ P M | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR April 30, 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Pre Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | |
| 13a. STATE Maryland | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 8715 Georgia Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harold ----- Hirshblond | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie ----- Shokestell | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. unknown | | 17. INFORMANT ADDRESS Potomac, Md. Leonard Winnick, 22 Old Creek Ct. | | | | |

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c) 410-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day
4 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebral Arteriosclerosis, Paranoid Schizophrenia | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/15 , 19 79 , to 1/31 , 19 79 , that (I) (we) last saw the deceased alive on 1/31 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE R. T. Benack MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/31/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS 4115 Colic Dr. Wheaton, Md 20806 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Feb. 2, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY Crescent Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pennsauken, N. J. | | |
| 24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Mem. Chap. 1170 Rockville Pk | | | | 25a. DATE REC'D. BY REGISTRAR FEB 5 1979 | | 25b. REGISTRAR'S SIGNATURE Barry McCready | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

08550-27

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-02231

| | | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Erik William Wolf | | | 2a. DATE OF DEATH MONTH DAY YEAR
01 16 79 | | | 2b. HOUR
6:10AM | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
AUG 23, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MISSOURI | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery Gen. Hosp., Olney | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CIVIL ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOVT. | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3530 CHISWICK COURT | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MAX WOLF | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELISE SCHWEIGLER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | 16b. SOCIAL SECURITY NO.
489-05-6150 | | 17. INFORMANT
LOUISE C. WOLF | | ADDRESS
SAME AS 13 | | WIFE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure.
492-
DUE TO, OR AS A CONSEQUENCE OF
(b) Emphysema.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
25 days | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
Constrictive Heart Failure. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-21 , 19 78 , to 1/16 , 19 79 , that (I) (we) last saw the deceased alive on 1/15/79 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Alberto Rotsztein | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALBERTO ROTSTEIN | | | 22e. ADDRESS
3701 Rosemoor Blvd.
Silver Spring, Md. 20906 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | | 23b. DATE
1/17/79 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA VIRGINIA | | | |
| 24. FUNERAL DIRECTOR NAME
FRANCIS J. COLLINS | | | 25a. DATE REC'D. BY REGISTRAR
JAN 19 1979 | | | 25b. REGISTRAR'S SIGNATURE
Robert A. Kelly | | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-02232

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Benjamin nmw Wolfe | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 3 79 | | 2b. HOUR
12 55 AM | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
1 16 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Electronic Tech. | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOVT. |
| 13a. STATE
Maryland | | 13b. COUNTY
Pr. Georges. | 13c. CITY OR TOWN
Hyattsville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harry B. Wolfe | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Flora Hurowitz | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW-2-Navy 225-10-3107 | | 17. INFORMANT
ADDRESS
Mrs. Jeannette Wolfe Same as No. 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>
2028 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Disseminated lymphoma</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>cause unknown</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 days months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Massive upper G.I. bleeding</u> | | | | | |
| 19a. DATE OF OPERATION
<u>angiography</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Bleeding - upper G.I.</u> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 20</u> , 19 <u>78</u> , to <u>Jan 3</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Jan 2</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>W.W. Bestman</u> | | DEGREE
M.D. | | 22c. DATE SIGNED
1-3-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/5/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Park Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Westwood, New Jersey | | 25a. DATE REC'D. BY REGISTRAR
JAN 10 1979 | | | |
| 24. FUNERAL DIRECTOR NAME
Donald M. Stein Hebrew Memorial F.H. | | 25b. REGISTRAR'S SIGNATURE
<u>notary</u> | | | |
| 232 Carroll Street, N. W. Washington, D. C. | | | | | |

10-05535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co/banpopers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 79-02233 |
|--|--|---|--|---|--|---|--|---|--|-------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
WINDOM H. YOUNG | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1-15-79 | | 2b. HOUR
9A M | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR
MAY 17, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
80 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
SILVERSPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Gardener | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | 13b. COUNTY
Montg | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1024 Quebec Terrace | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Hilary Young | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARY Foreman | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WN I | | 17. INFORMANT ADDRESS
2405 Buttonsville Rd. Silver Spring Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) UREMIA
4409
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ARTERIOSCLEROTIC VASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 WEEKS | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from MAR 28, 1978, to 15 JAN 79, that (I) (we) lost saw the deceased alive on 14 JAN 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Walter E. Goetz | | | | DEGREE
MD | | | | 22c. DATE SIGNED
15 JAN 79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALTER E. GOOZTH MD | | | | 22e. ADDRESS
2309 SHOREFIELD RD WHEATON MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
1-19-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Ash Mem. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Sandy Spring Montg Md. | | | | |
| 24. FUNERAL DIRECTOR NAME
George Snowden | | | | 24b. ADDRESS
246 N. Wash. St. Rockville Md. 20850 | | 25a. DATE REC'D. BY REGISTRAR
JAN 22 1979 | | 25b. REGISTRAR'S SIGNATURE
H. J. McCreedy | | |

10-05533

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-02234

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
John C.K. Yu M.D. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1/10/79 | | 2b. HOUR
6:02 PM |
| 3. SEX
MALE | 4. RACE
ORIENTAL | 5. DATE OF BIRTH
MONTH DAY YEAR
MARCH 18 1924 | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
CHINA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
GEN. SURGEON | 12b. KIND OF BUSINESS OR INDUSTRY
PRIVATE U.S. GOVT. | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
POTOMAC | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
10721 STANMORE DRIVE |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
E. S. YU | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
GRACE CHEN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Unavailable | | 17. INFORMANT
HELEN S. YU (SAME AS 13e) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4590 INTRA-ABDOMINAL BLEEDING
DUE TO, OR AS A CONSEQUENCE OF (b) UNKNOWN CAUSE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 DAYS |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
SUP. MESENTERIC ARTERY THROMBOSIS & NECROTIC BOWEL | | | | | |
| 19a. DATE OF OPERATION
1-8-79 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
INTRA-ABD. BLEEDING | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-8-79, to 1-10-79, that (I) (we) lost
saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
M.D. | | 22c. DATE SIGNED
1-11-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
IRA MILLER MD | | 22e. ADDRESS
8218 WISCONSIN AVE BETHESDA MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
1-12-79 | 23c. NAME OF CEMETERY OR CREMATORY
POTOMAC U.M. CHURCH CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
POTOMAC MONTGOMERY MD. |
| 24. FUNERAL DIRECTOR
NAME
ROBERT A. PUMPHREY FUNERAL HOMES P/A | | ADDRESS
ROCKVILLE MD. | | DATE REC'D. BY REGISTRAR
1-16-79 | |

48550-07

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02235
REG. NO. | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) HAROLD - YURICK | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/8/79 | | | | 2b. HOUR 8¹⁵ A.M. | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 31, 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mail carrier | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 9917 Valley Park Dr. | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Damascus | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Yurick | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Deminoise | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 2 | | 17. INFORMANT ADDRESS Doris E. Yurick, Item 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gastrointestinal Bleeding
DUE TO, OR AS A CONSEQUENCE OF (b) Liver cirrhosis
DUE TO, OR AS A CONSEQUENCE OF (c) Portal Hypertension
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR Jan 5 1979 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 5 1979 to Jan 8 1979 , that (I) (we) lost saw the deceased alive Jan 9 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED Jan. 8, 1979 | |
| 22b. SIGNATURE Boo K. Kim | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS Suburban Hospital, Bethesda, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Jan. 11, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY Pine Grove | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Airy, Carroll, Md. | |
| 24. FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 9 1979 | | | | 25b. REGISTRAR'S SIGNATURE | | | |

78-0550-25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| 1- FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02236
REG. NO. | | | |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Anastasia (Nellie) Zahoruiko | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 1, 1979 | | | | 2b. HOUR
12:17pm | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 29, 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Stitcher | | 12b. KIND OF BUSINESS OR INDUSTRY
Shoe factory | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Potomac | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
11605 Bedfordshire Avenue | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown Navarov | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | 16. ADDRESS
Rochester, NY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
014-10-5372 | | 17. INFORMANT
ADDRESS
Olga Evans 40 Dake Avenue | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest and Pump Failure
4109
DUE TO, OR AS A CONSEQUENCE OF
(b) Massive Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) Coronary Atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min
4 hrs
years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from November 1, 1978 to January 1, 1979 , that (I) (we) lost saw the deceased alive on January 1, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
G. Stuart Scott MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/1/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G. Stuart Scott, M.D. | | | | | | 22e. ADDRESS
10401 Old Georgetown Road Beth., MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/4/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Pine Grove Cem. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lynn, Massachusetts | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 2 1979 | | 25b. REGISTRAR'S SIGNATURE
Rifky McCurdy | | | |

10-05336

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 79-02237
REG. NO. | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) <i>Nereo</i>
<i>Zannoni</i> | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>1 7 79</i> | | 2b. HOUR
<i>9:57 PM</i> | | | |
| 3. SEX
<i>M</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>1 18 06</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>72</i> YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 2 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Italy</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>(Italy)</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Mont. County</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Springs</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Holy Cross Hosp.</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>—</i> | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>Va.</i> | | 13b. COUNTY
<i>Arlington</i> | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
<i>2301 Jefferson Davis</i> | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Eliseo Zannoni</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Elizabetta Zannoni</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>228-98-8853</i> | | 17. INFORMANT
Same as above
ADDRESS
<i>Franca Buchsbaum (Daughter)</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>cardiorespiratory arrest</i>
3500
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <i>acute anterior myocardial infarction</i>
(c) <i>diabetes mellitus</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/1</i> , 19 <i>78</i> , to <i>1/7</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>1/7</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Joseph M. Solinas</i> | | DEGREE
<i>MD</i> | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<i>1/7/79</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Joseph Solinas</i> | | 22e. ADDRESS
<i>9901 Georgia Ave. S.S.Md.</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Cremation</i> | | 23b. DATE
<i>1/12/79</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Ft. Lincoln Crematory Brentwood PG Md.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Hines/Rinaldi</i> | | ADDRESS
<i>F.H. 11800 N.H. Ave. S.S.Md.</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 11 1979</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

BP _____

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(VRA 15, 4) 7/78

10-05531



TO THE
HONORABLE
MEMBERS OF THE
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.
FROM
THE
COMMISSIONER OF THE
BUREAU OF REVENUE
WASHINGTON, D. C.

Very respectfully,
[Signature]
Commissioner of the Bureau of Revenue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 79-02238
REG. NO. | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
VINCENT PETER ZEDLER | | | | 2a. DATE OF DEATH MONTH DAY YEAR
Jan. 22, 1979 | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
Mar. 21, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Artist | | 12b. KIND OF BUSINESS OR INDUSTRY
Montg. Sentinel | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
Md. | | 13b. CITY OR TOWN
Montg. | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
30 O'Neill Drive | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Vincent I. Zedler | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Getz | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II 168-01-7621 | | 17. INFORMANT
Gaithersburg, Md.
John Zedler 754 Quince Orchard Blvd | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4274 IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Ventricular fibrillation</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<i>Atherosclerosis, portal hypertension, anemia, gastric</i> | | | | | | | |
| 19a. DATE OF OPERATION
<i>1/22/79</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Reparative anastomosis</i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/22/79</i> , 19 <i>79</i> , to <i>1/22/79</i> , 19 <i>79</i> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <i>1/22/79</i> , 19 <i>79</i> , and that (in) <input checked="" type="checkbox"/> my opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>H. Robert Birschbach MD</i> | | | | DEGREE
MD | | 22c. DATE SIGNED
<i>1/22/79</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
H. Robert Birschbach | | | | 22e. ADDRESS
<i>1040 Old Georgetown Rd</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Jan. 25, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Casimir Cem. | | 23d. LOCATION
Pittsburgh, Pa. | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Humphrey
Homes, P.A. Bethesda, Md. | | | | 25. DATE RECEIVED BY REGISTRAR
JAN 26 1979 | | | |

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